EFFECT OF ALCOHOL AND DRUG ABUSE ON PRODUCTIVITY

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON

ALCOHOLISM AND DRUG ABUSE

AND THE

SUBCOMMITTEE ON

EMPLOYMENT AND PRODUCTIVITY

OF THE

COMMITTEE ON

LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

TO REVIEW EMPLOYEE ASSISTANCE PROGRAMS FOR ALCOHOL AND DRUG ABUSE PROBLEMS IN AMERICAN INDUSTRY AND PROFESSIONS

JULY 14, 1982

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EFFECT OF ALCOHOL AND DRUG ABUSE ON PRODUCTIVITY

WEDNESDAY, July 14, 1982

U.S. SENATE, SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE, AND SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY, OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,

Washington, D.C.

The subcommittees met, pursuant to notice, at 10:05 a.m., in room 4232, Dirksen Senate Office Building, Senator Gordon J. Humphrey (chairman of the Subcommittee on Alcoholism and Drug Abuse) presiding.

Present: Senators Humphrey, Quayle, and Pell.

OPENING STATEMENT OF SENATOR HUMPHREY

Senator HUMPHREY. Good morning. I want to begin by thanking my colleague, Senator Quayle, for his interest in alcohol and drug abuse and its serious effect on the work force, and his efforts as well as those of his staff in making this hearing possible.

The costs to our society of alcohol and drug abuse in both financial and social terms are devastating. One recent study sponsored by the Alcohol, Drug Abuse and Mental Health Administration estimates that in 1977, alcohol and drug abuse cost the U.S. economy in excess of $65 billion. Needless to say, that rather astounding number does not take into account the pain, suffering, and family disruption that can never be assigned a monetary value.

Nearly half of these costs—$29 billion—is related to lost productivity due to employee alcohol and drug abuse. For some time, employers have been well aware that employee alcohol and drug abuse is linked to absenteeism, increased sick leave, turnover, lowered productivity, product loss, higher insurance rates, increased accidents and workers' compensation claims, poor judgment on the job, and greater amounts of management time spent with employees who abuse alcohol and drugs.

Labor and management have worked together extensively to improve programing for employees with alcohol and drug abuse problems. In particular, the number of programs in the field of alcoholism in the workplace has grown geometrically in the past decade.

From 1944 and the inception of the first known alcoholism program in a major, multiplant company by the Du Pont Corp., which is represented here today, employee assistance and employee alcohol programs have grown to over 5,000 programs nationwide serving 10.5 million workers.

Although the progress made in providing employee assistance programing in the workplace has been heartening, new challenges to industry are continually emerging. While many employee programs have been developed to serve the needs of the alcohol-abusing employee, a new, insidious problem in the work force has grown over the past two decades which must be addressed.

In the decades of the 1960's and the 1970's, we saw a tenfold to thirtyfold increase in the level of drug abuse by varying segments of the population, with the greatest increases among adolescents and young adults. The most recent survey of high school seniors, although showing a downward trend in marihuana use, still indicates that 7 percent of our high school seniors use marihuana daily.

I want to depart from my prepared remarks here to point out that we should not get too encouraged or complacent on the basis of this high school senior survey, since many of those, and perhaps most, who abuse drugs never make it to the point of being a senior, and so therefore are not included in these surveys.

As these students join the work force, drug abuse in the workplace will become an evermore dangerous problem. Fortunately, as needs change, industry has responded by broadening employee alcohol programs into employee assistance programs to address a wide range of needs, including drug abuse and more general counseling services.

However, the illegality of drug use in the workplace makes the problem for employers and employees especially complicated. Science is providing government and industry with increasingly effective techniques and devices to detect drug abuse, such as urine screening for marihuana and other drugs. How labor and management will use these tools is an important question for this decade.

The military, a large employer of young people between the ages of 18 and 25, has already felt the adverse effects of drug abuse in its work force. During a recent joint hearing of the Subcommittee on Manpower and Personnel and the Subcommittee on Preparedness, which I cochaired, we received extensive testimony on the effect of alcohol and drug abuse on the armed services and the programs being instituted to address the problem.

These programs are aimed at every aspect of the problem, from improved law enforcement efforts to extensive education, prevention, and treatment. Certainly, industry today faces the same challenges with its work force, and the members of our subcommittees would like to assist in heightening awareness on the issue and helping to find the most effective solutions.

I will at this point turn to my colleague, Senator Quayle.

OPENING STATEMENT OF SENATOR QUAYLE

Senator QUAYLE. Well, thank you very much, and I am certainly pleased to be here with Senator Humphrey to cochair these hearings and to receive testimony on alcoholism and drug abuse, and perhaps more particularly their effect on American productivity.

I do not think that there is any doubt that whatever we talk about in improving and expanding our GNP, the key word that comes up time and time again is the issue of productivity.

I certainly believe that alcoholism and drug abuse are perhaps America's No. 1 health problem, and I am alarmed that they are not recognized as such. Alcoholism is gaining on heart disease, cancer, diabetes, and stands a good chance of surpassing them within a decade as the Nation's No. 1 killer. Our country's drug addiction rate surpasses that of any other industrialized nation. The growth in both alcoholism and drug abuse continues essentially unchecked, unlike our efforts to control cancer, diabetes and other deadly diseases.

We pay dearly for alcohol and drug abuse. The human cost of pain and suffering is immeasurable. The price we pay for health care, days away from work and lost productivity as a result of addiction and alcoholism is about the same as the amount requested by the President to run the 400 programs in the Department of Health and Human Services—$70 billion.

Mr. Chairman, in the Subcommittee on Employment and Productivity, we held a series of hearings in March and April of this year on American productivity. We established an important record on the characteristics of high and low productivity industries and the various methods used to measure productivity.

I feel, however, that we cannot ignore the devastating effect that alcoholism and drug abuse has on American productivity. This is why my colleague, Senator Humphrey, and I are holding these hearings today. We hope to hear testimony that describes the scope of the problem.

Employees with a drinking or drug problem are absent 16 times more than the average employee, have an accident rate that is four times greater, use a third more sickness benefits, and have five times more compensation claims while on the job. These impaired employees function at slightly more than half their normal capacity. That, in and of itself, is quite an indictment on the severity of the problem that we face today.

With 13 million alcoholics in the United States and up to 53 million people using drugs occasionally, we are looking at almost 70 million workers performing at less than half their normal capacity daily.

Several of our witnesses today are employers who have decided to do something about the problem of the impaired worker. Senator Humphrey's subcommittee has held hearings on the growing problem of addicted youth in our Nation's schools. Today, we would like to follow those children as they move out of the school and into the work place.

We have learned that the earlier you reach an alcoholic or an addict, the greater the chance of success. Employee assistance programs help alcoholics and drug users in the work force to get treatment at early stages of the disease. They have literally helped thousands of employees and reaped substantial savings for the employer. But less than 12 percent of American workers have access to employee assistance programs.

Our witnesses today have all been involved in running successful employee assistance programs, in some cases for many years. It is my hope that their testimony will set an example for what the American employer can and should be doing about this grave and very costly problem.

So, I hope that during the testimony of our witnesses, which I know will be outstanding and constructive, we will focus on perhaps a rationale for why we have not paid the proper amount of attention to this problem; at least that is a perception on my part.

Second, I do believe that it is a very key issue on how we enhance productivity by defining the problem of alcoholism and drug abuse, how we encourage our employers to take more of an active role in this problem to get at the source at as early a stage as possible.

So, with that, Mr. Chairman, shall we proceed?

Senator **Humphrey**. We will now hear the opening remarks of Senator Pell.

Opening Statement of Senator Pell

Senator **Pell**. Let me preface my remarks this morning by thanking both the chairman of the Subcommittee on Alcoholism and Drug Abuse, and the chairman of the Subcommittee on Employment and Productivity for conducting this joint hearing. This subject matter is of particular interest to me because of my profound concern over the needless deaths that are caused on our highways due to drunk drivers. I have introduced drunk driving legislation in the Senate, S. 671, that will significantly reduce the number of deaths caused by drunk drivers. State drunk driving laws have already had a dramatic effect in my own State of Rhode Island, and I am confident that this national legislation will have the same positive results. It is not enough to get the drunk driver off the road, however. We need further measures to provide treatment for the disease of alcoholism so that we can attack the real root of this growing problem.

Our task this morning is to consider the effectiveness of programs provided to the alcoholic in the workplace, such as the employee assistance programs. The cost of alcohol abuse to productivity is staggering. It is estimated that 10 percent of the people in the work force are alcoholics or problem drinkers, and that the loss in productivity due to this abuse costs the United States $30.1 billion annually. Drug abuse represents a further annual loss of $8.3 billion. Forty percent of industrial fatalities can be traced to alcohol abuse, and this abuse has a significant effect on company morale.

Employee assistance programs are uniquely effective in treating this disease because of their accessibility to workers in their place of employment. I would like to commend the number of corporations, some which are represented today, that have been pioneers in the effort to treat alcoholism and drug abuse in the work place. EAP's are growing at an exponential rate, and many smaller businesses have joined together to form consortiums to treat their workers.

I am extremely encouraged by the impressive statistics regarding the accomplishments of the EAP's. For example, General Motors Corp. has identified savings of $3,700 per year for each employee successfully treated in its EAP. The success rate of occupational alcoholism programs is further confirmed by the Fourth Report to Congress of the National Institute on Alcoholism and Alcohol

Abuse, which also cites the effectiveness of early intervention with younger, less impaired workers.

I am hopeful that the increase in the number of occupational assistance programs will reduce the societal costs of the alcoholic—the stress the alcoholic's problem places on the family, the increase in the number of crimes and highway deaths, and the loss in productivity. It is imperative that we step up our examination of the causality and treatment of the fastest growing health problem in our country. We must learn more about why certain occupational and societal stresses seem to foster greater abuse. Working women, as an example, have a higher rate of addiction than working men. My own State of Rhode Island has one of the highest rates of alcoholism in the Nation, yet very little is known regarding the cause of this statistic. I expect that treatment of alcoholism through the EAP's will provide a better understanding of the factors that contribute to problem drinking, and I am confident that this hearing will offer useful information for improving our treatment of alcohol and drug abuse.

At this point we will receive for the record prepared statements by Senator Hawkins and Senator Denton.

PREPARED STATMENT OF SENATOR PAULA HAWKINS

Senator **HAWKINS**. Mr. Chairman, I would like to take this opportunity to express my concern over the effects of alcoholism and drug abuse on productivity in our society. Alcoholism has emerged as the fourth most prevalent health problem today, closely following heart disease and cancer. No segment of our society is exempt from this problem which touches the lives of between 5 and 10 percent of all American workers. Drug abuse, although it has not received as much attention as the alcoholism problem, is a growing problem in the U.S. work force. The illicit drug industry is an $80 billion a year business and it is estimated that as many as 6 million workers in the United States may be currently abusing drugs. Needless to say, both the personal and the economic ramifications flowing from this problem are as high as a loss of $100 billion per year, $25 billion of which is directly attributable to lost productivity.

The detrimental effects of alcoholism and drug abuse which contribute to lower productivity range from increased absenteeism to increased accidents on the job to less efficient performance. It has been estimated that 40 percent of all on-the-job accidents are alcohol-related, alcoholics being two to three times more prone to accidents than nonalcohol abusers. In one State alone, 16 percent of drivers arrested for unsafe driving were found to be under the influence of drugs.

Often it appears that employees turn to alcohol or drugs as a means of coping with the daily stress of the workplace. Due to this fact, combined with the fact that such a large amount of alcohol and drug abuse occurs while actually at the worksite, the workplace has emerged as a highly appropriate and effective site for combatting this problem. In the past decade, many employers have begun to realize the advantages of providing assistance programs for employees suffering from alcoholism, drug abuse or other personal difficulties which adversely influence their job performance. The key component in any successful business venture lies in its people.

Consequently, it is only good business sense for firms to strive to maintain their employee's physical and mental well-being at all times. One way of accomplishing this goal is through the establishment of EAP's, employee assistance programs. Twelve percent of all firms in the United States presently provide EAP's for their employees. Basically, an EAP is a counseling service employers provide for employees suffering from alcoholism and drug abuse which lead to decreased productivity on the job. For smaller firms unable to provide these services due to a lack of resources, consortiums are sometimes formed to provide counseling for a number of smaller firms.

I would like to take this opportunity to commend those firms which have already established EAP's and to urge more firms to exercise their good business sense by doing so. Overall, the success ratio of EAP's falls between 50 and 70 percent. Consequently, it is evident that the provision of these programs by firms is not only a humane action; it is also a wise investment in the future of their business. Only by combatting the problem of alcoholism will we be able to alleviate the problems associated with these illnesses which damage so many human lives and lower the productivity of American business. This is a goal which we must share as we rebuild the American economy.

PREPARED STATEMENT OF SENATOR JEREMIAH DENTON

Senator **DENTON**. I want to begin my remarks by commending each of you for taking the lead in examining and publicizing a critical national problem: The effects of alcohol and drug abuse on the productivity of the American worker.

The problem of alcohol and drug abuse, and the resulting decline in work performance, is certainly not a new one. Recent studies, however, reveal its pervasiveness and the tremendous toll it extracts from the American business community, the American health care system, and the American economy as a whole. Estimates of the cost to society from absenteeism due to substance abuse, from shoddy workmanship performed by substance-dependent workers, and from health benefits paid to workers, range as high as $70 billion a year, a truly astounding figure.

Studies have indicated that the workplace ranks only behind the home as the place where the effects of substance abuse first become apparent. It follows that early detection in the workplace offers one of the best opportunities for the treatment of persons suffering from chemical addiction.

It is heartening to know that many companies, including some from whom we will hear today, have moved promptly to institute training programs for supervisors to help them identify illnesses caused by alcohol or drugs. Other firms have developed counseling and treatment programs for their employees suffering from substance dependency. Those efforts are praiseworthy. They demonstrate how far business has come in recognizing the benefits of treating sick employees and returing them to work, rather than ignoring the problem and casting them adrift.

Only through the redoubled efforts of management and labor can we beat back the spreading disease. I am encouraged by the progress thus far. Some studies have found that programs emphasizing early detection and treatment of addicted individuals can achieve success rates of 60 to 80 percent, a figure that translates into tremendous savings in health care expenditures and marked increases in productivity. But employers must first realize that the problem can exist in their own company.

Although some companies have implemented exemplary employee assistance programs, and the Federal Government's Office of Personnel Management has developed its own program, other firms will not even acknowledge that their employees could possibly have alcohol or drug abuse problems. Raising the awareness of those firms is a formidable task, but hearings like this one will publicize the enormity of the problem, and will spread the word about the benefits that accrue to both employees and management from effective employee counseling programs. I am anxious to hear about the efforts of the firms that sent representatives to testify about their programs.

I hope that, through the actions of both the private sector and the Federal Government, through outreach activities conducted by the Alcohol, Drug Abuse, and Mental Health Administration, more companies will become aware of the tremendous opportunities that now exist to make significant gains in the fight against alcohol and drug abuse.

Thank you.

Senator HUMPHREY. We look forward to hearing from our witnesses, many of whom have traveled substantial distances at their own expense. We are pleased to welcome both the Associate Director of the Office of Personnel Management and the Administrator of the Alcohol, Drug Abuse and Mental Health Administration, who will discuss the efforts of the Federal Government in providing services to their substantial work force and disseminating model programing and policy considerations.

In addition, we welcome representatives of many private firms and labor groups with model employee assistance programs, as well as Mr. Califano and Mr. Bensinger, who have been assisting both States and private industry in the development of alcohol and drug programing.

Our first panel is comprised of Dr. William Mayer, who is the Director of the Alcohol, Drug Abuse and Mental Health Administration of the U.S. Public Health Service; and Mr. Michael Frost, who is the Associate Director for Workforce Effectiveness and Development at the Office of Personnel Management.

Good morning, gentlemen. Dr. Mayer, will you begin, please?

STATEMENT OF WILLIAM MAYER, M.D., ADMINISTRATOR, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION, U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND MICHAEL R. FROST, ASSOCIATE DIRECTOR, WORKFORCE EFFECTIVENESS AND DEVELOPMENT, OFFICE OF PERSONNEL MANAGEMENT

Dr. **Mayer.** Thank you, Mr. Chairman, Senator Quayle. It is really a very great honor and a tremendous pleasure to represent Secretary Schweiker in these hearings. We would like to express at the outset our tremendous gratitude to you and your committee staff, in particular, for the support that you have consistently given to our efforts to get at the problems of drug abuse and alcohol abuse and alcoholism.

I do not want to repeat much of the very excellent material that was in both of the opening statements. I would like to add to it, however, that the magnitude of the problem is hard to overestimate. In addition to some of the figures on absenteeism and the numbers of people involved, I would like to point out that about 40 percent of all industrial fatalities seem to be connected with alcohol use, and about 47 percent of all industrial injuries. The alcoholic worker is two to three times as likely to be injured or killed in an industrial accident as a person not so dependent.

While it is true, and I agree emphatically, that the magnitude of the problem is enormous, I would like also to point out that in the field of alcoholism, particularly, over the years and now increasingly in the field of drug abuse, what has happened in this country perhaps better than any other activity that I know of exemplifies the interaction that can occur, to great social benefit, between Federal Government, State, and local government, private industry, including both management and labor, and the voluntary sector, as exemplified, for example, by the National Council on Alcoholism, Alcoholics Anonymous, and many growing professional associations of alcohol and other treatment counseling staff and professionals.

The real beginnings in this country of a change, a turnaround in what had been generations of stigma and ignoring the problem and denying the problem I think really started in the forties and was primarily the result of activity by industry and by organized labor, along with the patient, continuous, sincere efforts of the members of Alcoholics Anonymous.

As you know, a predecessor in the Senate introduced a bill about 11 years ago which resulted, in 1972, in the establishment of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. That 10 years has seen, in my judgment, clearly more profound change and greater improvement in our whole attitude and our approach to the treatment of these serious human ills than had occurred in the whole previous history of mankind.

In these last 10 years, for example, we have seen a growth in the industrial programs, generally called employee assistance programs, from fewer than 300 to more than 5,500 in that decade. At the same time during that period in order to foster the development of workplace programs, the National Institute on Alcohol Abuse and Alcoholism sent 100 consultants, two to each State, not to provide them with programs but to encourage the development of programs in connection with State government and in connection with private industry.

That was a time-limited program; the government had no intention of operating it. They did it for 3 years. Those 100 people are now represented by 3,000 people, paid for with State funds, all over the United States who are engaged in technical assistance, consultation, and the promotion of workplace treatment and early intervention programs.

During that same decade, we have seen a growth from a relatively small number, a few hundred at most—some would say many fewer than that—of legitimate, organized, thoughtful treatment programs for alcoholics. From those few, we have seen a growth to where we can now identify more than 4,500 treatment facilities available in the country.

And lest it be thought again that this is some achievement of simply pouring out large amounts of Federal money, it is not. Only about 14 percent of the treatment facilities around the country are supported by Federal funds.

What I am trying to say is that there has been a huge improvement in our recognition of the nature and the extent of this social and health problem, and the reason for its success has to be shared by Government and industry and labor and the voluntary groups. But there are other reasons for this success and the growth of the program, which is not yet enough to deal with the problem but certainly holds promise, as few things do, of successfully attacking what would otherwise be an increasing and devastating social ill.

I think the first reason for the improvement that we have seen in recent years is the recognition, beginning with recognition by the American Medical Association and the World Health Organization, that alcoholism is, in fact, a disease. I often hear it said that it is a self-inflicted disease and therefore those of us who do not do this to ourselves should not have to bear the brunt of taking care of those who do.

But I submit that much cancer, like cancer of the lung due to cigarette smoking, is equally self-inflicted; that athletic injury on the part of a kid who goes and plays basketball and breaks his ankle, since there is quite a risk of that in athletics, is also a self-inflicted injury, as much as becoming an alcoholic in a society which essentially condones and practices the use of alcohol.

So, to dismiss these things as failures in character, as some kind of defect in the individual, or as unworthy of the attention of science and of government and of private enterprise, is missing the point altogether. We have recognized that it is a disease.

We believe very strongly—and our scientific evidence shows good evidence—that it has genetic components and that it has important metabolic abnormalities connected with it. Our research is progressing at a rate unprecedented in the past now that the disease is becoming respectable, and we are finding out more and more about the true nature of dependency upon alcohol and other drugs.

The second reason for the growth and the success that we have seen so far, which I fully expect, thanks partly to the efforts of you and your staff and committees of this sort in bringing it to public attention, and the testimonials that recovering alcoholics have been giving, and some of the athletes that are now talking about their drug abuse—a major additional reason for the success of our efforts in these fields is the fact that we have a good product; it works.

It is possible to treat alcoholism; perhaps not to cure it in the sense of making it go away forever. In fact, we believe at this stage of our knowledge that that is not possible. But we can treat it successfully, and the innumerable, splendid industrial programs designed for early intervention and referral for proper treatment are great testimony to this fact.

It pays off, first of all, in human terms that are almost incalculable. It is estimated that every alcoholic has a serious impact on at least three or maybe four other people, both in his workplace and in his home. So, the number of alcoholics, if, in fact, they do constitute 10 percent of those drinkers—the number of alcoholics in this country and those impacted directly by them is simply astronomical.

So, since the programs that are in existence today throughout the country are consistently reporting 60 to 80 percent success rates, meaning helping individuals turn their lives around and to live without being dependent on chemicals and to be able to resume a normal level of productivity—when we can receive, as we have, reports consistently of 60 to 80 percent success in achieving that, then we have a success rate that is unmatched in most of the rest of medicine and is really tremendously hopeful for the future.

It is easy, therefore, that there is a human benefit. It is almost equally easy to show that there is cost benefit that makes sense to the businessmen and the lawyers and the accountants and the people who run governments and who run major industry that give this country its strength.

We showed, for example, in a program in the Armed Forces that I was privileged to operate in Europe a few years ago that if, out of 600 patients that we admitted in the course of a year for treatment, we only succeeded in helping 3 to resume a normal, full-fledged, productive role in the Armed Forces, the savings by saving only 3 of the 600 paid for the entire program for an entire year. Of course, our results were closer to between an 85- and 90-percent success rate.

Our present emphasis in government is on backing away from simply supporting direct treatment services, and even some withdrawal from the support of training people to give those treatment services. That is partly because we think it can better be done outside of government.

Certainly, the growth of the industrial alcohol programs is great testimony to this fact. We are instead concentrating—and Secretary Schweiker has repeatedly emphasized that his top priority is disease prevention and health promotion. That implies, of course, that we deal with the behaviors of people that contribute to their lack of wellness and to their disease, and the behaviors of people that contribute to recovery from diseases; not just diseases that are clearly behavioral at least in some part, like the taking in of chemicals or of alcohol, but behavioral disorders such as living in a stressful environment and failing to learn to cope with stress adequately; of using, for example, cigarettes when it is known that there is a direct link between that and cancer of the lung and between cigarette smoking and cardiovascular disease.

We know that behavior as it relates to health is the great future for achieving that goal of all health, which is prevention, not treatment after the fact when something bad already has happened.

Now, in keeping with our prevention emphasis, I think it is very important to understand the public health concept of secondary prevention. We do not have the primary prevention of an inoculation, like for smallpox, against disasters to the individual resulting from his use of alcohol and drugs.

Secondary prevention, however, is considered to be early intervention, as you mentioned—vigorous treatment early on before irreparable damage occurs and before the individual is so locked into whatever the disease process is that he is very difficult, if not impossible, to treat.

What we have seen growing in industry today, in the private sector, very strongly supported by the volunteers in NCA and AA—what we have seen growing is the most effective kind of secondary prevention—the early intervention in the workplace—and the workplace is second only to the family as the place where the problems begin to show up—early intervention in the workplace, referral to legitimate sources of treatment, support for the individuals, and withdrawal from the old-fashioned attitude of, "Well, he cannot be any good; he is a drunk; let us get rid of him," which is the punitive attitude that has never worked in dealing with this or any other disease.

So, what we are seeing today is a model, I believe, in dealing with alcohol and with drugs. We are seeing a model of what the future holds in our ability to prevent disease in the first place and to stop it in such early stages that we can tremendously contribute to the quality of life of our citizens and to people all over the world, and also, and not incidentally, to effect enormous savings in money, property and in lives lost that otherwise result.

Our National Institute on Alcohol Abuse and Alcoholism, our National Institute on Drug Abuse, and the National Institute on Occupational Safety and Health—the first two, in particular, are concentrating very heavily now what resources we have on research.

That research is not just laboratory research with test tubes and rats. That research importantly looks into effective treatment programs, systems for delivering services, evaluative programs to make it possible to determine exactly what the benefit, and what the value of the activities that are going on are.

We will continue that kind of research along with our laboratory biomedical research, which is beginning to open up whole areas of new understanding about the human brain and about human behavior.

We will continue at the Federal level to collect information and to work with industry, as we have in the past, and with labor and with the States and communities. We will continue to disseminate information. We will continue to support the parents groups that are growing all over the country—concerned groups of parents who have probably had some significant impact on the reduction in marihuana use, but who have as yet, along with the rest of us, not been able significantly to impact the growing problem of alcohol abuse among youngsters.

I think that if the momentum is kept up with industry and Government continuing to operate in this loose but very comfortable and very productive alliance, we can foresee the day when these health problems, which I agree with Senator Quayle, are among, if not are, the leading health problems in America, will be subject to our control and management.

I would like to conclude by stating that we have had a good relationship with the Office of Personnel Management, from whom you are about to hear. Secretary Schweiker is directed by statute to work closely with the Director in order to develop model programs for our employees.

I am accompanied today by the Director of the National Institute on Drug Abuse, Dr. William Pollin; the Acting Director of the National Institute on Alcohol Abuse and Alcoholism, Mr. Loren Archer; and Dr. Dale Massey, who is the Director of our employee assistance program, which we call the Employee Counseling Service, within the Department of Health and Human Services, serving the whole 142,000 of us, and serving us very well with some marvelous innovations, such as our new weekend and evening treatment program for Federal employees, which OPM is supporting and which Blue Cross-Blue Shield is funding.

With that, I thank you for your attention. I think that you are talking about something of enormous importance—still a terrible problem, but one which we have gotten a grip on, thanks to interaction in and out of Government that is unparalleled in the health field. Thank you.

[The prepared statement of Dr. Mayer follows.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

FOR RELEASE ONLY
UPON DELIVERY

STATEMENT OF

WILLIAM MAYER, M.D.
ADMINISTRATOR

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

U.S. Public Health Service

Department of Health and Human Services

BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

and the

SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

WEDNESDAY, JULY 14, 1982

Mr. Chairman, I am pleased to have the opportunity to be here today to discuss with you the important issue of the effects of alcohol and drugs on productivity.

The impact of alcoholism and alcohol and drug abuse on our nation is devastating, both in terms of human suffering and in economic costs to our society. According to a recent study conducted by the Research Triangle Institute for the Alcohol, Drug Abuse, and Mental Health Administration, the U.S. loses -- in direct and indirect costs -- nearly $50 billion a year due to problems associated with alcoholism and alcohol abuse. This includes health care costs, fires, accidents, and violence. Most striking, lost productivity and unemployment account for more than half of this amount, or $26 billion. The economic costs of drug abuse to the nation were estimated to be in excess of $15 billion in the same study of the year 1977. Of this amount, more than $3 billion was due to lost employment and reduced productivity in young males alone (18-24 years old). We believe this is a conservative estimate since it does not include the contribution of drug use to crimes in our society.

IMPACT OF ALCOHOL AND DRUG ABUSE AT THE WORKPLACE

In May of this year more than 100 million persons were employed in this country. It is generally accepted by professionals in the alcoholism field that between 5 and 10 percent of the workforce suffer from alcoholism. Workers suffering from alcoholism are at least 25 percent less productive than their co-workers. American business and industry have become increasingly aware that the small shop, the office, and the factory are also not immune to other drug abuse problems. However, it is even more difficult to pinpoint the nature and extent of drug abuse among American workers. There is no uniform policy regarding drug detection, and studies generally have relied on self-report surveys which have definite limitations. Therefore, estimates of the impact of drug abuse in industry must be viewed with caution. Managers often are unaware of the signs and symptoms of drug abuse in people with whom they are working. Both alcohol and drug abusers can sometimes filter unidentified through the most careful and elaborate personnel procedures, and they often can be marginally productive on the job.

While we recognize the limitations of the available data, I can report that studies have estimated consistently that 3 to 7 percent of the employed population use some form of illicit drug on a regular basis -- ranging from marijuana to heroin. This is believed to be a problem among American workers in addition to the 5 to 10 percent who have alcohol problems, although there is some overlap in these populations.

In a study conducted under a National Institute on Drug Abuse contract, nearly 5000 interviews were conducted surveying drug usage by employees in more than 200 companies. The emerging picture suggests that although employee drug use is of relatively low incidence in any single company, it is prevalent throughout the industrial sector. Projecting the 6 percent incidence rate found in this survey would indicate that as many as 6 million workers in the United States may be currently abusing drugs.

In this study, marijuana appears to be the primary substance of use: 90 percent of current drug users indicated use of marijuana, and 37 percent of all current drug users reported use of marijuana exclusively. Use of amphetamines was cited by 34 percent and use of barbiturates was cited by 21 percent of the respondents, although nearly all respondents reporting use of these drugs also report use of marijuana. Use of heroin was cited by 5 percent of the respondents. All heroin users also reported use of other drugs, usually including marijuana.

The impact of alcohol and drug abuse on an employee in a work setting can be wide-ranging. It includes effects on both the employee and the employer:

- higher accident rates
- loss of productivity
- decreased quality of work products
- increased absenteeism
- increased average level of sickness benefits
- increased health insurance premiums
- increased workers compensation claims
- increased grievance submissions
- increased thefts on the job
- increased employee turnover
- increased interpersonal and morale problems.

While the use of alcohol and drugs at the worksite presents a clear and present danger, alcohol and drug consumption off the job can also impair work performance in a number of ways, inasmuch as alcohol and many drugs remain active in the body for differing periods of time. The public danger of this problem is clearly evident for certain occupations such as pilots, air traffic controllers, bus, train, or taxi drivers, nuclear power plant operators, and military personnel. Alcohol and drug abuse can create a variety of security problems ranging from theft of company property, to compromising individuals in sensitive positions.

By any method of quantification the abuse of alcohol and drugs has a substantial negative impact on productivity. Whatever the dollar estimate that is attributable to lost productivity, these figures can never truly reflect the amount of human suffering, pain, misery and disruption of family life which can be associated with an individual's alcohol or drug abuse.

HEALTH PROMOTION AT THE WORKPLACE

The work setting is now being looked upon as one place where individual alcohol and drug abuse problems can be identified early and confronted effectively, and where users can be provided treatment and rehabilitation interventions while they still are able to work productively. In this effort, we have worked closely with business and industry.

Indeed, the workplace setting has been identified as a key focus in Secretary Schweiker's Health Promotion Initiative, which is at the top of the Department's agenda. He is placing high priority on bringing to the attention of all our citizens the ways in which behavior influences health. The Secretary's program will stress basic good health habits and identify behaviors that are linked to disease, disability and death. Among these is the abuse of alcohol and drugs.

The fact is that behavioral choices can be a factor in every one of the ten leading causes of death in this country. Alcohol may be a factor in six. Our own choices and our own behavior have a powerful influence on our health. When we, as a nation, fully understand that fact -- and learn what each of us can do for ourselves -- we will become an even healthier and more productive people. The Department's new Health Promotion Initiative aims to help all Americans learn more about what they can do to enhance their health.

The Initiative itself is multifaceted: it will involve research to determine more precisely the links between behavior and health; it will seek to increase knowledge of disease prevention facts and health promotion techniques among our nation's health professionals; and it will involve a significant new public education effort, including a nationwide media campaign.

Our decision to put special emphasis on health promotion in the workplace setting seeks to translate knowledge of good health behavior into action. By moving health promotion into the place where so many productive hours are spent, we can bring the benefits of health into the main current of American life.

As more American corporations are learning each year, health promotion programs at the workplace can mean healthier employees, better attitudes toward work, lower absenteeism, early detection of disease...and productivity. In fact, it is now estimated that more than 1,000 corporations in this country are investing some $2 billion per year in employee health and fitness programs.

The link that this committee has so well recognized in calling these hearings -- the link that connects behavior with health and health with our productive capacity -- is increasingly recognized in the private sector itself. Combatting alcoholism and drug abuse is very much a part of the concern for the health and productivity of the American worker.

DEVELOPMENT OF EMPLOYEE ASSISTANCE PROGRAMS

Now, as you know, the strategy of engaging industry and labor in helping to reduce alcohol and drug abuse in the workforce is not new. In fact, alcohol occupational programs pioneered in this endeavor in the late 1940s. These programs have proven enormously successful in reducing suffering and restoring individuals to satisfactory work performance. During the 1950s, there were approximately 50 such programs in this country. Since then, there has been nearly a 100-fold increase in their number. Today there are more than 5000 programs in the United States.

In the early days, programs began primarily as alcohol occupational programs -- centering on the assumptions that impaired performance is recognizable, that alcoholism is treatable, and that acceptable work performance is an expected outcome of treatment. As they developed, it became clear that such programs also had to address a wide range of issues affecting employees, such as drug abuse, family problems, stress, and even financial difficulties. Most programs then expanded to what we refer to today as employee assistance programs (EAPs).

I would like to acknowledge some of the many forces that have fostered the development of EAPs. Without these efforts we would not have achieved the progress we have made.

American industry has taken serious and significant steps in assisting employees with alcoholism or alcohol-related problems. In 1972, a sample survey which included Fortune 500 corporations indicated that approximately 25 percent of these firms had developed programs to identify and assist persons with a drinking problem. By 1979, 57 percent of these major employers had EAPs.

The mid-1970s brought a tremendous increase in occupational programs: from about 300 in 1972 to more than 5,000 in both the public and private sectors covering 10 million workers. It is important to note that 70 percent of these programs are prepared to assist with both alcohol and drug abuse. In a recent study, EAPs were reported to have achieved a rate of 50 to 70 percent in successful rehabilitation.

In sum, the overall impact of EAPs can be enormous, and when designed to work also with family members, the EAP can play an important role that cannot be duplicated elsewhere in our society.

Organized labor has been another major force behind bringing this assistance to the American worker. Unions have been actively involved in the design, development, and promotion of EAPs.

Problem drinking, drug abuse and other problems are becoming more commonly addressed in collective bargaining, and unions also have worked to assure that health insurance benefits are available to persons in need of treatment. Many unions now view inclusion of such benefits as a standard part of the collective bargaining process.

The Committe is scheduled to hear today from representatives of industry and labor who will address their experiences with the EAP.

Private organizations also have figured critically in the development of occupational programming, notably the National Council on Alcoholism (NCA), the Association of Labor and Management Administrators and Consultants on Alcoholism (ALMACA), and the Occupational Program Consultants Association. Since the 1960s, NCA has supported pilot occupational programs and published a journal focusing on occupational program issues. ALMACA's membership of more than 3,000 has undertaken a broad range of activities designed to promote the development of occupational programs at State and local levels.

The Congress, with its concern over the problem, has been highly supportive and instrumental in the progress being made. As you know, the Congress enacted legislation which established the National Insitute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute for Occupational Safety and Health (NIOSH).

These laws have required the Secretary of Health and Human Services to develop model alcohol and drug abuse programs suitable for replication on a cost-effective basis, and to make these models and information about them available to State and local governments and the private sector. Both NIAAA and NIDA have developed such models and disseminated them widely, and NIOSH is now in the process of developing other models.

In addition, the Office of Personnel Management has been mandated to develop and maintain alcohol and drug abuse programs and services for Federal civilian employees. In 1980, the Congress broadened the program to include family members who are alcoholics and drug abusers. You will be hearing testimony directly from the Office of Personnel Management concerning the Federal programs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) ROLE AND ACTIVITIES

I shall now summarize briefly some of the major activites DHHS has undertaken over the last decade to further the growth of alcohol and drug abuse occupational programming.

National Institute on Alcohol Abuse and Alcoholism

- Since 1972, NIAAA has obligated almost $48 million for grants to various agencies, organizations and businesses throughout the country to stimulate the development and growth of occupational alcoholism programs. Some grants were awarded to set up a network of occupational programming consultants to assist in developing programs at State and local levels. Other grants funded model and demonstration programs. The chief models being promoted by the Institute are (1) the consultation model, (2) the assessment and referral model, and (3) the diagnosis and treatment model.

- The Institute also has supported activities to develop training programs for occupational program consultants and program administrators new to the field.

- NIAAA actively disseminates information on model programs, largely through the Institute's National Clearinghouse for Alcohol Information.

- NIAAA provides technical assistance upon request to various groups, businesses, and governments (including Federal agencies) on alcoholism occupational programs. With a decade of experience, the Institute is now able to offer assistance to any size or type of organization or business.

- While the Institute's primary focus has been on providing assistance in the development of occupational progams, we also have supported research on several aspects of delivering these services -- such as, barriers to the use of occupational programs, supervisor reaction to alcohol problems and policies, and evaluation of the effectiveness of occupational programs.

- NIAAA has supported an evaluation project in conjunction with the Department of Defense and the Office of Personnel Management to evaluate the effectiveness of Federal EAPs.

National Institute on Drug Abuse

- NIDA has focused its work on identifying and describing the drug abuse problem among workers, developing model occupational programs, and assessing the impact of occupational programs. A 1977 NIDA survey assessed the extent of drug use in industry and, through evaluation of current occupational drug abuse programs, developed a "how to" monograph. "Developing an Occupational Drug Abuse Program" provides practical considerations and guidelines for companies interested in establishing a drug abuse program. NIDA has distributed the monograph to more than 3,000 major private companies nationwide.

- NIDA, in cooperation with the Blue Cross Association and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), is conducting a project to demonstrate the marketability and administrability of a comprehensive Alcohol and Drug Abuse Treatment Benefit at three Blue Cross Plans (Blue Cross and Blue Shield of Alabama, Blue Cross of Greater Philadelphia and Blue Cross of Northeastern New York), to obtain data on benefit cost and utilization. After 21 months of marketing more than 66,000 members are covered by the benefit at the three demonstration sites. The benefit expands coverage for residential and outpatient rehabilitation, both in hospital and freestanding facilities, at a monthly premium that ranges from 35 to 82 cents for an individual and $1.00 to $1.70 for a family.

- NIDA, through a contract, has assisted in the development of drug abuse prevention programs for use in the workplace, and has increased efforts to help union representatives expand the focus of EAPs from a treatment-only orientation to include prevention projects. A new monograph designed to help employees, managers, and unions to develop effective prevention policies and programs for drug and alconol abuse will be available soon.

Centers for Disease Control

- The Centers for Disease Control (CDC) has worked closely with the public health agencies of State and local governments to help build capacity for health education and risk reduction programs in these agencies. Several States have active interests in worksite health promotion. For example, New York has established a Wellness in the Workplace Consortium, composed of the State Health Department, the State University of New York, and 17 local health promotion organizations and voluntary agencies. Through this program, local industries will be helped to foster employee programs aimed at reducing risk factors the employees choose to address. Alcohol and drug abuse are two of the several health promotion areas.

The DHHS Employee Counseling Service (ECS)

The Department is working in cooperation with the Office of Personnel Management to develop and maintain certain aspects of the Employee Counseling Service (ECS) program for which the DHHS has special expertise.

The ECS program in DHHS, located in the Office of the Assistant Secretary for Personnel Administration, has as its main objective the continued improvement of employee job performance as it is affected by alcoholism, drug abuse, and/or personal/emotional-related problems. The program is now well under way for 142,000 HHS employees. Secretary Schweiker has given strong support to these efforts and the Department's liasion with other Federal departments.

Furthermore, an OPM-HHS Letter of Agreement delineates the DHHS role in developing model programs for all Federal agencies. Each agency's respective role in policy and program guidance, consultation and technical assistance, training, program review, and evaluation and research has been specified in the agreement. Special demonstration projects have been and are being developed as follows:

- An ECS Supervisory Training Package addresses itself to training Federal managers and supervisors to confront troubled employees whose work performance is deteriorating.

- A film entitled "ECS: A Supervisor's Alternative" realistically portrays the situation a supervisor may find when trying to work with a troubled employee.

- Other demonstration projects address themselves to troubled employees who are difficult to reach. For instance, the Senior Executive Service (SES) program model now being negotiated will provide special strategies and outreach activities for SES members' special needs.

- The Field Employees model plans to make ECS available to those employees in remote locations.

- The Evening and Weekend Alcoholism Treatment Project funded by Blue Cross offers an alternative to more traditional in-patient and out-patient facilities. It allows employees without significant sick or annual leave accumulation to participate in intensive treatment after working hours. Moreover, child care is available for parents who may otherwise not be able to receive treatment.

Perhaps the most critical mandate of the ECS program is to develop a uniform evaluation system to demonstrate the program's cost-effectiveness. It will measure the effects of the program on work performance over time as well as the effects of the program on selected variables such as absenteeism rates, health insurance claims, and sick and annual leave patterns. Such an evaluation system should be a major contribution to the occupational field for both the Federal and private sectors.

THE STATE OF THE ART

We have learned a number of things from all our collective efforts thus far, among them:

- EAPs can have a positive effect on individuals and their productivity.
- Although much concern has been expressed regarding costs of alcohol and drug abuse problems to industry, little attention has been focused on the specific industrial and occupational factors that contribute to these problems (e.g., job stress, job complexity, nature and degree of supervision).
- The workplace can be the site at which problem drinking and drug abuse occurs, as well as a major contributing factor to these problems.
- Barriers to the development of employee assistance programs include attitudes of decision-makers (corporate or union), company management style, organizational structure, real versus perceived prevalence of alcohol and drug abuse problems, ambiguity in definition of goals, and measurement of meaningful outcomes.

- Certain population groups which could potentially benefit from occupational programs are currently inadequately served or not served at all. These include many women, minority groups, some professionals, workers in small businesses, farm workers, and college students.

We also have discovered that many questions are yet unanswered and for which we need more information. For example:

- We need better information on the use and abuse of alcohol and drugs among employees of different occupational groups and work roles.

- We need to give greater attention to factors that can inhibit or facilitate the successful re-entry and aftercare of workers, including differences that might apply to employees in different occupations.

- We need additional information on the most appropriate role for supervisors in the identification and referral process and the ability of supervisors to effectively confront an alcohol or drug abusing employee.

- We need to understand the impact of the work environment itself on the drinking problem or deviant drinking and/or drug-taking behavior of employees.

FUTURE DIRECTIONS -- DHHS ACTIVITIES

With the rapid growth of EAPs, we need to encourage more research to answer these questions. While common sense dictates and many business and industry studies verify the experience that these programs are successful, additional evaluation studies with rigorous research designs are needed.

In May 1980, NIAAA sponsored a workshop with participants from research, industry, and government to review the state of our knowledge, discuss research issues, and make recommendations for future research. Recommendations were developed in the areas of:

- Epidemiology of alcohol abuse and alcoholism in occupations and organizations.
- Risk factors associated with occupations.
- Barriers to the development of programs.
- Design and integration of intervention mechanisms.
- Dynamics of identification and referral.
- Interorganizational relationships.
- Psychodynamics of the return and follow-up process.
- Evaluation of programs.

The workshop results have been disseminated to the field in a Research Monograph that summarizes the state of the art and recommendations for future research. In addition, the Institute has been engaged in several other research activities. Among these is a project to investigate the use of alcohol by young adults (aged 17-24 years) now being undertaken in collaboration with the Department of Labor through the 1982 Youth Cohort of the National Longitudinal Surveys. This project will examine the relationship between occupational experience and patterns of alcohol consumption and alcohol-related problems, as well as other possible influences, such as age, sex, racial/ethnic background, education and job training.

We are also making progress in developing a simple, inexpensive diagnostic procedure that can readily distinguish between individuals who have drinking problems and those who do not. As part of these studies, we are undertaking a collaborative effort with the Department of Defense to further develop the diagnostic utility of this technique.

NIDA's current research efforts applicable to drug abuse in the workplace focus on collaborative efforts with the Department of Defense (DOD) both in developing the DOD urine detection program and in providing technical expertise in the assessment of military performance impairment due to drugs.

NIDA research efforts have led to the development of new technology in the screening and assessment of drugs from body fluids. This technology, which is now commercially available, can provide reliable, inexpensive urine screening for a variety of abused substances. NIDA is currently providing technical assistance to a number of large corporations which are using this technology to screen employees for drug use. NIDA has taken the lead and is working with the White House Drug Abuse Policy Office, as well as several other government agencies, to develop policy guidelines for the use of urine detection techniques within the Federal Government. It is anticipated that these guidelines will serve as a model for private industry.

CDC's National Institute for Occupational Safety and Health and its Center for Health Promotion and Education jointly are considering how to stimulate adoption of model health promotion programs for workers. CDC is especially interested in models that team the offical State health agency, the employer, and the employee in effective collaboration. CDC's intent is to encourage a public health approach to health promotion in the worksite, as a way to assure access to comprehensive health promotion services. For example, the 17 community- based agencies in the New York Consortium now offer 60 programs in the areas of substance abuse education, physical fitness, personal and organizational stress management, smoking cessation, nutrition education, and weight control.

As this brief review clearly indicates, we are proud of our accomplishments in the important areas of technical assistance, research, development and application of knowledge to problems which impair the productivity of our nation. We are gratified to see that the private sector, both industry and labor, have built upon from our research and demonstration efforts, and we will continue to disseminate our latest information toward the goal of relieving these health problems and increasing the productivity of the American workforce.

I would be pleased to answer any questions you might have.

Senator **Humphrey**. Thank you, Dr. Mayer. Let us go right to Mr. Frost for his statement and then we will have some questions. Let me thank both of you, while I am thinking of it, for submitting your statements early enough to give us an opportunity to review them, particularly since you are not reading them verbatim this morning.

Mr. Frost?

Mr. **Frost**. Thank you very much, Senator Humphrey and Senator Quayle. It is my great pleasure to be here to represent OPM Director Donald Devine. I am Associate Director of the Office of Personnel Management, and included in my responsibilities is the Employee Health Services Branch, which has the alcohol and drug abuse program Government-wide.

My purpose here today is to explain how this operation works within the Federal Government. I am a program manager; I am not an expert in alcoholism and drug abuse, per se. The goal of the Government-wide program on alcohol and drug abuse counseling is designed specifically to train supervisors and managers to recognize problems which may affect employees' job performance and to help the employee find the appropriate assistance particularly where alcoholism or drug abuse is involved.

These programs are authorized by two laws: Public Law 91-116, which is the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972.

The first law gives OPM, in cooperation with the Secretary of Health and Human Services, responsibility for leadership in directing the internal Government program dealing with alcoholism and drug abuse among Federal civilian employees. The second law gives us similar responsibilities specifically related to drug abuse.

Deteriorating performance really is the standard by which we determine whether intervention of this program is necessary. The purpose of the program is to identify the nature of the problem, not to provide specific treatment itself.

Now, obviously, it is not always possible to know what is causing deteriorating performance and whether that deteriorating performance is due specifically to alcoholism or drug abuse. Thus, ultimately, the counseling that is given to Federal employees with deteriorating performance may deal with alcoholism and it may deal with drug abuse. It could also deal with other problems, such as emotional problems, marital problems, financial problems—any kinds of things which may ultimately result in deteriorating job performance.

What happens is that the agency, through the counseling program, identifies the deteriorating performance, identifies, if they can, what the problem is related to, and then refers to an outside community resource for counseling for the specific problem that is identified.

Now, the Office of Personnel Management's Employee Health Services Branch is responsible for assisting Federal agencies in establishing programs to aid employees with alcoholism and drug abuse. The way we carry out this responsibility is that we develop and issue formal policy guidance. We provide technical assistance and training programs, particularly for managers, supervisors, and counseling staff. We also monitor the counseling activities to try to determine their effectiveness through our annual reporting program.

This is a program which OPM establishes the guidance for. It is actually operated by the individual department, and for the most part we find that these programs are similar to programs found in the private sector.

We have really two aspects: identification of the problem and referral, and orientation for new employees and training programs for supervisors and managers on how to deal with this problem.

The size of an agency counseling staff will vary depending upon the size of the agency. At a very large installation, there may be one or more full-time counselors. At installations with smaller populations, there may be part-time counselors.

In fiscal year 1980, agencies reported that 745 staff years had been expended in this program. Now, these are Federal employee staff years. It does not include the substantial amount of counseling time that was spent in programs that were contracted out to private companies, and probably that figure, which we do not have a figure on, is greater than the 745 staff years of Federal time.

Since the time we began to compile statistics on this program, approximately 81,000 Federal employees have been counseled specifically for alcohol and drug abuse problems; 90 percent of those were for alcoholism and 10 percent were for drug abuse. In addition to that, another 162,000 employees have been counseled for other types of personal problems.

So, in just fiscal year 1980, which is the last year we have statistics available for, 12,000 employees were counseled for alcoholism, about 1,400 for drug abuse, and 20,000 for other types of problems which caused deteriorating job performance.

We have seen a yearly increase in the number of alcoholism and drug abuse cases treated in the Federal work force. We have also seen a large percentage of this number helped to the point where acceptable job performance is restored. In fiscal year 1980, 78 percent of the alcoholism cases and 73 percent of the drug abuse cases resulted in restoration of job performance. So, the program is effective.

There is also another method of providing this kind of counseling for Federal installations with small populations in the same geographic area. In 1980, OPM developed and issued guidelines for agencies on the establishment of counseling consortia, and these guidelines really are an alternative approach for providing counseling for agencies that have small populations.

In this arrangement, agencies join together through a formal contractual agreement with a private firm and establish a counseling program for their employees. This approach requires one or more agencies to serve as the principal contracting agency, and this may be one of the participating agencies, it may be the Public Health Service of HHS, or where neither of these options is feasible, it may be OPM.

In fact, presently there are seven such consortia throughout the country. The Office of Personnel Management is the lead agency for two of them, one in Boston and one in Detroit. Actually, our policy is to encourage the establishment of these consortia because we believe that it will provide the kind of services with the efficiency and economy that an agency would be unable to obtain by trying to establish their own program.

The program not only provides counseling; it also can provide training to managers, supervisors, and employees. In the Federal system, it is important not only to train employers and managers as to how to recognize the problem, but to train them on what the appropriate steps are to take when they do find that there is a problem.

Also, in order to help us assess the program, we have recently let a contract to review programs at six Federal installations within a 200-mile radius of the Washington area. We did this to find out what effect the counseling programs are having on employee performance appraisals, absenteeism, on-the-job accidents, and all of those kinds of issues.

The National Council on Alcoholism estimates that an effective alcoholism program should be able to identify 1 percent of the work force each year as having alcohol-related problems, and what we are doing in these six installations is testing out that hypothesis.

We decided to limit the geographic area to minimize contract cost, but as a result of this project, which will be completed in March of 1983, we will obtain the necessary information to decide what changes, if any, are needed in the current program and the current guidance program.

To summarize, the Federal Government as an employer views these counseling programs as an integral part of our personnel management system. We will continue to provide at OPM the Government-wide leadership and direction necessary to establish and improve these programs and provide the kind of training and technical assistance necessary to carry them out.

We will also insure that we continue to maintain our close working relationship with the Department of Health and Human Services in carrying out these programs in the Government.

I appreciate very much the opportunity to testify and we will be very pleased to answer any questions you might have. Thank you very much.

[The prepared statement of Mr. Frost follows:]

STATEMENT OF
MICHAEL R. FROST
ASSOCIATE DIRECTOR, WORKFORCE EFFECTIVENESSS AND DEVELOPMENT
AT A
JOINT HEARING OF
ALCOHOLISM AND DRUG ABUSE SUBCOMMITTEE
AND
EMPLOYMENT AND PRODUCTIVITY SUBCOMMITTEE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
ON THE
IMPACT OF ALCOHOL AND DRUG ABUSE ON THE WORKPLACE AS WELL AS THE EFFECTIVENESS OF EMPLOYEE ASSISTANCE PROGRAMS
JULY 14, 1982

CHAIRMAN HUMPHREY AND CHAIRMAN QUAYLE AND MEMBERS OF THE SUBCOMMITTEES:

I APPRECIATE THIS OPPORTUNITY TO TESTIFY ON FEDERAL EMPLOYEE ASSISTANCE PROGRAMS THROUGHOUT THE GOVERNMENT, THEIR EFFECTIVENESS, UTILIZATION, STAFFING, AND IMPACT ON FEDERAL EMPLOYEES.

ONE OF THE MOST IMPORTANT GOALS OF THE OFFICE OF PERSONNEL MANAGEMENT (OPM) IS TO IMPROVE THE MANAGEMENT OF THE FEDERAL WORK FORCE THROUGH PERFORMANCE APPRAISAL, MERIT PAY, AND OTHER PERFORMANCE BASED INCENTIVES. IN SUPPORT OF THIS GOAL, EFFECTIVE EMPLOYEE COUNSELING PROGRAMS ARE DESIGNED SPECIFICALLY TO TRAIN SUPERVISORS AND MANAGERS TO RECOGNIZE PROBLEMS WHICH MAY AFFECT AN EMPLOYEE'S JOB PERFORMANCE AND TO HELP THE EMPLOYEE FIND APPROPRIATE ASSISTANCE, PARTICULARLY WHERE ALCOHOLISM OR DRUG ABUSE IS INVOLVED.

THESE PROGRAMS ARE AUTHORIZED BY TWO LAWS, THE COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970 (P.L. 91-616) AND THE DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972 (P.L 92-255). THE FIRST LAW GIVES OPM, IN COOPERATION WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES, RESPONSIBILITY FOR LEADERSHIP IN DEVELOPING AND MAINTAINING APPROPRIATE PROGRAMS DEALING WITH ALCOHOLISM AND ALCOHOL ABUSE AMONG FEDERAL CIVILIAN EMPLOYEES. THE SECOND LAW ASSIGNS SIMILAR RESPONSIBILITY TO OPM IN DEVELOPING AND MAINTAINING PROGRAMS TO REDUCE DRUG ABUSE AMONG FEDERAL EMPLOYEES. THESE TWO LAWS MANDATE THAT FEDERAL DEPARTMENTS AND AGENCIES ESTABLISH ALCOHOLISM AND DRUG ABUSE COUNSELING PROGRAMS FOR THEIR EMPLOYEES. DETERIORATING PERFORMANCE INDICATES THAT A PROBLEM MAY EXIST AND IS THE BASIS FOR REFERRING AN EMPLOYEE TO THE COUNSELING SERVICES PROGRAM STAFF.

THE PURPOSE OF AN EMPLOYEE COUNSELING SERVICES PROGRAM IS TO IDENTIFY THE NATURE OF THE PROBLEM, NOT TO PROVIDE TREATMENT ITSELF. RATHER, THE EMPLOYEE IS REFERRED BY THE COUNSELOR TO AN OUTSIDE COMMUNITY RESOURCE FOR THE NECESSARY TREATMENT.

THE OPM EMPLOYEE HEALTH SERVICES BRANCH IS RESPONSIBLE FOR ASSISTING FEDERAL DEPARTMENTS AND AGENCIES IN ESTABLISHING NEW, OR IMPROVING ALREADY EXISTING, PROGRAMS TO AID EMPLOYEES WITH ALCOHOL OR DRUG ABUSE PROBLEMS. IN CARRYING OUT THIS RESPONSIBILITY WE DEVELOP AND ISSUE FORMAL POLICY AND GUIDANCE, PROVIDE TECHNICAL ASSISTANCE, AND PROVIDE TRAINING PROGRAMS TO AGENCY MANAGERS, SUPERVISORS, AND COUNSELING PROGRAM STAFF. IN ADDITION, WE MONITOR AGENCY COUNSELING ACTIVITIES AND DETERMINE THEIR EFFECTIVENESS THROUGH OUR ANNUAL INTERAGENCY REPORTING SYSTEM. AGENCIES, USING OUR GUIDANCE, ESTABLISH THEIR OWN INTERNAL PROGRAMS AND USE THEIR OWN RESOURCES IN OPERATING THESE PROGRAMS. FOR THE MOST PART, THESE PROGRAMS ARE SIMILAR TO THOSE FOUND IN THE PRIVATE SECTOR. THE FEDERAL EMPLOYEE COUNSELING PROGRAMS HAVE TWO ASPECTS: (1) IDENTIFICATION OF THE EMPLOYEE'S PROBLEM AND REFERRAL TO AN APPROPRIATE OUTSIDE RESOURCE FOR REHABILITATIVE ASSISTANCE, AND (2) ORIENTATION FOR NEW EMPLOYEES AND TRAINING PROGRAMS FOR SUPERVISORS AND MANAGERS IN IDENTIFYING AND ASSISTING TROUBLED EMPLOYEES. THE OVERALL GOAL OF THE GOVERNMENT-WIDE PROGRAM IS TO IMPROVE THE PERFORMANCE OF EMPLOYEES IN THE PUBLIC SECTOR.

THE SIZE OF THE AGENCY COUNSELING STAFF VARIES DEPENDING UPON THE NUMBER OF FEDERAL EMPLOYEES AT A GIVEN FEDERAL INSTALLATION. AT INSTALLATIONS WITH SEVERAL THOUSAND EMPLOYEES THERE MAY BE ONE OR MORE FULL-TIME COUNSELORS. INSTALLATIONS WITH A SMALLER EMPLOYEE POPULATION (1,000 OR LESS) GENERALLY HAVE A PART-TIME COUNSELOR. IN FY 1980, AGENCIES REPORTED THAT A TOTAL OF 745

STAFF YEARS HAD BEEN EXPENDED IN PROGRAM ADMINISTRATION AND IMPLEMENTATION. HOWEVER, THIS FIGURE DOES NOT INCLUDE THE SUBSTANTIAL AMOUNT OF COUNSELING TIME THAT IS SPENT IN PROGRAMS THAT ARE CONTRACTED OUT TO A PRIVATE COMPANY OR OTHER ORGANIZATIONS. THUS THE TOTAL AMOUNT OF TIME DEVOTED TO EMPLOYEE COUNSELING PROGRAMS IS GREATER THAN THE 745 STAFF YEARS.

SINCE THE TIME WE BEGAN TO COMPILE STATISTICS (FY 1972) ON THE NUMBER OF EMPLOYEES WHO HAVE RECEIVED COUNSELING THROUGH AGENCY PROGRAMS, 80,995 FEDERAL EMPLOYEES HAVE BEEN COUNSELED FOR ALCOHOLISM AND DRUG ABUSE PROBLEMS. APPROXIMATELY 90 PERCENT OF THESE WERE FOR ALCOHOLISM AND 10 PERCENT WERE FOR DRUG ABUSE. IN ADDITION, 162,617 EMPLOYEES HAVE BEEN COUNSELED FOR OTHER TYPES OF PERSONAL PROBLEMS. IN FY 1980, THE LATEST YEAR FOR WHICH STATISTICS ARE AVAILABLE, 12,081 EMPLOYEES WERE COUNSELED FOR ALCOHOLISM, 1,386 WERE FOR DRUG ABUSE, AND 20,083 WERE COUNSELED FOR OTHER TYPES OF PROBLEMS. ALTHOUGH WE HAVE SEEN A YEARLY INCREASE IN THE NUMBER OF ALCOHOLISM AND DRUG ABUSE CASES TREATED, WE HAVE ALSO SEEN A LARGE PERCENTAGE OF THIS NUMBER HELPED TO THE POINT WHERE ACCEPTABLE JOB PERFORMANCE HAS BEEN RESTORED. IN FY 80, 78 PER CENT OF THE ALCOHOLISM CASES AND 73 PERCENT OF THE DRUG ABUSE CASES FELL INTO THIS CATEGORY.

IN ORDER TO STRENGTHEN THE EFFECTIVENESS OF ALCOHOLISM AND DRUG ABUSE PROGRAMS AT FEDERAL INSTALLATIONS WITH SMALL EMPLOYEE POPULATIONS IN THE SAME GEOGRAPHICAL AREA, OPM

DEVELOPED AND ISSUED (IN MAY 1980) GUIDELINES FOR AGENCIES ON THE ESTABLISHMENT OF COOPERATIVE EMPLOYEE COUNSELING PROGRAMS (CONSORTIA). THESE GUIDELINES SUGGESTED SEVERAL ALTERNATIVE APPROACHES FOR DEVELOPMENT OF PROGRAMS MOST LIKELY TO PROVIDE EFFECTIVE REHABILITATIVE OPPORTUNITIES FOR EMPLOYEES WITH JOB PROBLEMS STEMMING FROM ALCOHOLISM AND DRUG ABUSE.

ONE OF THE MOST FREQUENTLY USED APPROACHES IS THE ESTABLISHMENT OF A CONSORTIUM OF SMALL AGENCIES. IN THIS ARRANGEMENT, AGENCIES JOIN TOGETHER AND, THROUGH A FORMAL CONTRACTUAL AGREEMENT WITH A PRIVATE ORGANIZATION, ESTABLISH AN APPROPRIATE COUNSELING PROGRAM FOR THEIR EMPLOYEES. THIS APPROACH REQUIRES THAT ONE AGENCY MUST SERVE AS THE PRINCIPAL CONTRACTING AGENT FOR ALL OF THE PARTICIPATING AGENCIES. THE AGENCY WHICH SERVES AS THE CONTRACTING AGENT/BROKER MAY BE:

- ONE OF THE PARTICIPATING AGENCIES,
- THE PUBLIC HEALTH SERVICE (HHS), OR
- WHERE NEITHER OF THESE OPTIONS IS FEASIBLE, OPM.

THERE PRESENTLY ARE SEVEN CONSORTIA IN OPERATION THROUGHOUT THE COUNTRY, AND OPM IS THE LEAD AGENCY FOR TWO OF THEM, ONE IN BOSTON AND ONE IN DETROIT. OUR POLICY IS TO ENCOURAGE AGENCIES TO ESTABLISH AND USE COOPERATIVE PROGRAMS WHEN INCREASED EFFICIENCY AND ECONOMY WILL RESULT AND NEITHER PROGRAM EFFECTIVENESS NOR ESSENTIAL INTERNAL ADMINISTRATION

OF THE AGENCY WILL BE HAMPERED. THESE PROGRAMS REPRESENT AN EFFECTIVE AND ECONOMICAL APPROACH TO COUNSELING AND AT THE SAME TIME PROVIDE TRAINING TO MANAGERS, SUPERVISORS, AND EMPLOYEES ON ALCOHOL AND DRUG ABUSE RELATED PERFORMANCE PROBLEMS, WHICH WOULD NOT OTHERWISE BE AVAILABLE AT INSTALLATIONS WITH SMALL NUMBERS OF EMPLOYEES. WE EXPECT TO SEE A CONTINUED GROWTH IN CONSORTIA IN THE COMING YEARS.

IN AN ATTEMPT TO BETTER ASSESS AND DOCUMENT THE ACTUAL IMPACT OF COUNSELING PROGRAMS, OPM AWARDED A CONTRACT LAST YEAR TO REVIEW THE PROGRAMS AT SIX FEDERAL INSTALLATIONS WITHIN A 200 MILE RADIUS OF WASHINGTON. WE DECIDED THAT SIX SITES WOULD PROVIDE A SUFFICIENT BASE FOR DETERMINING THE IMPACT THAT COUNSELING PROGRAMS HAVE ON EMPLOYEE PERFORMANCE APPRAISALS, ABSENTEEISM, ON-THE-JOB ACCIDENTS, ETC. THE ACTUAL SITES WERE SELECTED BECAUSE THEY HAD GOOD PROGRAMS IN TERMS OF THE NUMBER OF EMPLOYEES WHO HAVE PARTICIPATED IN THE COUNSELING PROGRAMS. THE NATIONAL COUNCIL ON ALCOHOLISM ESTIMATES THAT AN EFFECTIVE OCCUPATIONAL ALCOHOLISM PROGRAM SHOULD BE ABLE TO IDENTIFY ONE PERCENT OF THE WORK FORCE EACH YEAR AS HAVING ALCOHOL RELATED PROBLEMS. THE SIX INSTALLATIONS FOR THE PROJECT MEET THIS PARTICULAR CRITERION. WE DECIDED TO LIMIT THE GEOGRAPHICAL AREA TO A 200 MILE RADIUS OF WASHINGTON IN ORDER TO MINIMIZE CONTRACT COSTS. AS A RESULT OF THIS PROJECT, WHICH WILL BE COMPLETED IN MARCH 1983, OPM WILL OBTAIN THE INFORMATION NECESSARY TO DECIDE WHAT CHANGES IN

CURRENT PROGRAM POLICY NEED TO BE MADE IN THE AREA OF ALCOHOLISM AND DRUG ABUSE PROGRAMS.

IN SUMMARY, THE FEDERAL GOVERNMENT, AS AN EMPLOYER, VIEWS EMPLOYEE COUNSELING PROGRAMS AS AN INTEGRAL PART OF A PROGRESSIVE PERSONNEL MANAGEMENT SYSTEM. OPM WILL CONTINUE TO PROVIDE GOVERNMENT-WIDE LEADERSHIP AND DIRECTION IN THE ESTABLISHMENT AND IMPROVEMENT OF EMPLOYEE COUNSELING PROGRAMS THROUGH ISSUANCE OF PROGRAM POLICY, GUIDANCE, AND TECHNICAL ASSISTANCE. WE WILL ALSO ENSURE THAT TRAINING FOR AGENCY SUPERVISORS, MANAGERS, AND COUNSELING PROGRAM STAFF IS AVAILABLE THROUGH INTERAGENCY TRAINING PROGRAMS OFFERED BY OUR OFFICE OF TRAINING, BOTH HERE IN WASHINGTON AND THROUGHOUT THE COUNTRY AT OUR REGIONAL TRAINING CENTERS.

I APPRECIATE THE OPPORTUNITY TO TESTIFY HERE THIS MORNING. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator Humphrey. Thank you, Mr. Frost.

Dr. Mayer, you noted rightly that there has been an enormous change in attitudes over the last 40 years, toward alcoholism, and that change in attitudes has enabled the community to make substantial progress in addressing this problem.

In your opinion, to what extent has the Federal Government been a force or an agent in this change of attitudes, and particularly the Institute on Alcohol Abuse and Alcoholism?

Dr. Mayer. It is my opinion that the National Institute on Alcohol Abuse and Alcoholism has played a really major role in that attitude changing.

Senator Humphrey. I thought you would say that. [Laughter.]

I am sure you are right.

Dr. Mayer. Well, you know, I did not belong to it for the first 9 years, so I am not saying it strictly out of loyalty to the organization.

Senator Humphrey. Yes.

Dr. Mayer. But the National Clearinghouse on Alcohol Information that has been operated throughout the existence of the Institute—and that was one of its major, early thrusts, a recognition by the authors of the legislation that there was a tremendous need for attitude change, so they have done a lot of it.

Senator Humphrey. Well, are you saying then that the principal function of the Institute and the Federal Government has been dissemination of information? Is that a correct characterization?

Dr. MAYER. No, sir. That is a principal function, the other ones being the actual support and assistance with the conduct of treatment programs, a major training effort, and a major research effort, so that like any great health academic institution, there is a three-pronged approach.

But communicating the findings and the ideas is, of course, critical to the success of those other endeavors.

Senator HUMPHREY. Yes, I am sure you are right. Secretary Califano will be testifying this morning, as I recall from his statement—that approximately 70 or 80 percent of those responsible in private firms are unaware of the success of employee assistance programs, unaware of the alternatives they have in addressing the problem of alcohol and drug abuse, which is an amazing thing for me to find out. So, obviously, there is still a lot of work to be done in that sector.

Do you agree with that estimate or with that finding?

Dr. MAYER. I certainly have no reason to disagree with it. I would expect that that is quite true because what we are trying to undo, really, is hundreds, if not longer, years of a belief that this is a whole subject that should not even be talked about.

The alcoholic, his family, and his coworkers all tend to deny the existence of the problem, and by deny it, I do not mean just say that it is not there, but kind of pretend it is not there. I am sure that applies to a great many businesses and industries still today.

Senator HUMPHREY. I found that passage in Secretary Califano's testimony, which says that in a survey of managers whose companies have no employee assistance program, 78 percent said they did not believe such programs would save their companies money. Yet, it is dramatically documented that these programs not only pay for themselves, but save substantial sums. Yet, 78 percent of those responsible are not of that opinion.

Furthermore, 90 percent reported that their companies did not have a serious problem with employee alcoholism. That is interesting.

You reported a success rate for treating alcoholism of 60 to 80 percent. Over what span of time was that success rate?

Dr. MAYER. Well, that is why I gave such a large span, because there are many definitions involved of what is absolute success.

Senator HUMPHREY. Yes.

Dr. MAYER. In the programs that I was familiar with in the military, we took as success a period of at least 2 years during which the individual had no further problems with alcohol, even allowing for the fact that he was under careful scrutiny because he was known to have received treatment for it.

Our studies have shown that after what we consider to be adequate treatment for alcoholism, the failure rate or most of the failure that takes place takes place within the first year. Those who are going to revert to a dependency lifestyle are going to revert generally in the first year, and by the end of the second year the people who are still functioning, in the overwhelming majority, are apparently going to stay intact and without further problems with the disease indefinitely.

So, I cannot speak universally for all the people who have reported from the many different treatment facilities that success level, but it is so consistently reported now that I believe that it is valid, and that is an enormous success rate.

Senator **Humphrey**. Yes. Well, you referred to avoidance of further problems, but in the case of alcoholics, is it not a medical fact that they must avoid alcohol completely?

Dr. **Mayer**. Absolutely.

Senator **Humphrey**. Therefore, are you saying that the success rate means that they have avoided alcohol?

Dr. **Mayer**. For practical purposes, true success in the management of chronic alcoholism, in my professional judgment, requires absolute abstinence for ever and ever from alcohol.

Senator **Humphrey**. Yes, I understand.

Dr. **Mayer**. There are many alcoholics who have had slips. It is very important in the management of the individual case that a slip, a slide-back or an episode not be interpreted as all being lost and he is back to where he started.

Senator **Humphrey**. Yes.

Dr. **Mayer**. So, there is a great deal of subjective interpretation possible in determining what is success. But the bottom line, if you will forgive me, is whether the individual can go back to work and pull his share of the load and is not interfering by his use of alcohol with any significant area of his life.

Senator **Humphrey**. Senator Quayle?

Senator **Quayle**. Dr. Mayer, I would be interested if you could perhaps define for us what you believe should be the proper role of the Federal Government in working with alcohol and drug abuse in American private industry.

Do you see this as primarily a problem that is going to have to be resolved by the private sector, basically, alone? What kind of involvement, what kind of interaction, what kind of policy should our Federal Government have in this area?

You know, the obvious concern and question is many people say, well, it is a problem, but beyond collecting data and making nice reports, there is no role for the Federal Government. As a matter of fact, this committee is not considering any legislation; we are just having hearings on the problem.

I would be curious if you could try to define for us a viewpoint on what the role of the Federal Government should be in this area with the private sector.

Dr. **Mayer**. Thank you; I would be happy to. A most important Federal role in further success in dealing with alcoholism and drug abuse is going to be the support of research. We have vast areas that we need to know about as to the nature of these diseases and how the brain functions with respect to these chemicals.

We need a great deal of additional information about what really works and what works over time. Finally, we need a great deal of research into what preventions measures show real success. Again, it is going to be necessary to study cohorts of individuals for long periods of time to be really certain of the success of prevention intervention, for example, and that I believe is a legitimate Federal role—the whole research enterprise.

Now, we both conduct research through our own employees, but we also mainly support research that is investigator-initiated in the great teaching and learning institutions around the country. That, I think, is a very important thing for us to do.

Now, with regard to industry, I think our job has changed. I think it quite properly was, back in 1975 when they sent the galloping 100 out, two to a State, to encourage people to get involved in industrial alcohol programs—I think that was legitimate at that time.

Now, however, I believe we can be of more assistance and I think it is a more proper Federal role that we be available to lend the technical assistance to companies and organizations of all sizes. The small ones have obviously been slower at getting involved, but we have a consortium system that is developing in the country whereby a number of small businesses get together, just as we are doing with some of our own personnel who are in far-flung places, none of which is big enough to support a program of its own. But joining together in a kind of a consortium is a legitimate way to provide a program.

We can help with that, partly because of our own experience and partly because we are the repository for reports of successful program intervention from all over the country. So, I think that our role mainly should be a technical assistance, guidance when asked, convenor of the thinkers and the doers in these fields for the establishment of sensible national policies; not to develop those policies necessarily, but to provide the kinds of thinking and information that should go into the development of those policies which are the Congress business.

So, the Federal role is still a very important one. There is no other way, for example, to collect really significantly sized amounts of data so that we can draw valid and legitimate conclusions.

It has to be borne in mind continuously that we are dealing in an area that is just layered over with superstitions, with myths, with false ideas, and with poor perceptions.

Finally, I think the Federal Government has a role in the training particularly of those young scientists who should be entering the field of research in this particular area of human need. This has not been a popular field. It has not been something fashionable for the researcher to do.

Research training in the development of career researchers in this field, which is still a new one in research, is critical to its further advancement.

So, those I think are the main functions that the Federal Government should have.

Senator **Quayle**. I wonder if you might be willing to go a little bit beyond the statement of lending technical assistance and guidance, when asked, and discuss with me perhaps the way that we can achieve success stories out in the work place where there would be a visible, highly understood successful story beyond just working within the realm of the normal Government structure on research and data, which I do not want to underestimate. I do not want to deemphasize it; I think it is very important. If we do not have that basis and that infrastructure, then the other job would be very, very difficult.

But I am thinking more in the area of private sector task force initiatives dealing with drug abuse and alcoholism on productivity.

I am thinking perhaps more of demonstration projects out in a particular business or industry where you would have the cooperation and the technical assistance from your people working in the private sector with business and labor—something that we could go out and say, "Look, we achieved this together."

Now, am I going too far too quickly?

Dr. **Mayer**. I do not think so at all.

Senator **Quayle**. Are we doing something in this area, and if so, what?

Dr. **Mayer**. Well, we have done a number of demonstration projects over the years with exactly that goal in mind of being able to show some success to our efforts. I think we can go farther than that; for example, the one that we are doing closer to home, of course, with OPM with respect to the six different sites within 200 miles of the Washington area. We are doing the evaluation of those undertakings.

Today, you are going to hear, I think—I have not read the testimony, but I would expect that you will hear from major industries in the United States as to the successes that they have already achieved. And there may be no better forum than this for getting that kind of information out to the public.

It is true that we, to the limit of our fiscal ability, will continue to try to stimulate demonstrations, perhaps with joint funding between government and industry, to demonstrate the effectiveness. There is still a long way to go in that respect because while I think many or most of the people in this room today are probably convinced—we are preaching to ourselves—of the importance and the value of doing these things, just like in the studies that you quoted, there are an awful lot of businesses that it has never occurred to that this is a problem in their company or that it is worthwhile in investing in it or that any good would come from it.

There is a huge public informational campaign that is still required, and we see that as a major project of ours, which is why we are continuing to support our clearinghouse. We do convene the best heads in the business that we can find for their advice on our advisory council and in our peer review groups as we study the proposals that investigators make to initiate research.

We have a very active media campaign going on right now, particularly with respect to alcohol use among women and young people. And those are all very important Federal activities, I think. I share that belief with you, and I think that is what you are saying.

Senator **Quayle**. I certainly concur that some of the undertakings that you have ventured forward on have been very worthwhile. But I think you sort of said it yourself that perhaps we are all talking to ourselves in this room today.

We will find out later on that there are a tremendous number of programs that the private sector has undertaken on their own. We are going to have some testimony in that respect.

But the bottom line is, and this is my concern, how do we get that message out? I mean, how do we get the understanding of the severity and the depth and the gravity of the problem? This, to me, seems to be the alarming fact as we study the situation here. We can cite the statistics of as many as 70 million people involved in drug or alcoholism in some respect, with the impact on productivity and how terrible it is.

Yet, later on it may receive some attention and some publicity, but tomorrow it will be something else. There has got to be something more that needs to be done. I do not know what it is. Perhaps we can have more of these hearings and more of us will have to follow this a lot closer and a lot more actively to expand our horizons, because the way that this problem is understood is, "You know, that may be John Smith's problems, but not mine," or "that may be the business' down the street with their particular work force, but certainly not mine."

We know that that is pervasive throughout our society. There is no community, whether it is Huntington, Ind., which is the town I am from, of 16,000, or New York City—the problems in these areas are still there, and very similar as far as the disease itself is concerned.

So, what I was trying to withdraw is, you know, what stick of dynamite is it that we perhaps need to light to get this thing in its proper perspective where I think it should be.

Dr. **Mayer**. Well, in that connection, some of our research is aimed at identifying professional groups and occupational areas in which the incidence of abuse of substances seems to be higher than in others, and the number of such high-stress occupations comes to mind.

One of those could conceivably be the public media, and if we could light them up with a recognition of how important this is in the successful prosecution of their duties, we can perhaps enlist more of the private sector in communicating about what needs to be done and what can be done, which is the crux of it, than we have in the past. These hearings are a tremendous help, believe me.

Senator **Quayle**. Well, thank you, Dr. Mayer.

Mr. Frost, at the conclusion of your testimony you indicate, "OPM will continue to provide Government-wide leadership and direction in the establishment and improvement of employee counseling programs through the issuance of program policy guidance and technical assistance." In your testimony, you underscored the problem that we have all identified today.

But I wonder how the decision of OPM to do away with the health benefits on alcoholism and drug abuse will have an impact on whether this really is a Government-wide leadership or not.

Mr. **Frost**. Well, I would be happy to respond to that. What we were faced with in the Federal employee health benefits program last year was a cost overrun of about $440 million. It is true that OPM mandated cuts in benefits? We have about 126 carriers who are part of the Federal employee health benefit program.

We did not mandate any specific program cut, but we did mandate an overall cut to deal with this $440 million cost overrun. Individual carriers made their own decisions about which programs they would cut. Some of them did, in fact, reduce benefits for alcoholism and drug abuse counseling, but that was an individual carrier decision based on whatever they felt their own priorities were in providing health benefits. It was not an OPM-mandated decision.

Our only decision was that we had to deal with that $440 million cost overrun.

Senator **QUAYLE**. But the decision could have been made to spread the cuts over all the services and make sure that the benefits for all services were basically kept; everyone could have accepted a proportion of it. That was not the decision, and the result is rather perplexing to me particularly in this area of drug abuse and alcoholism which we are dealing with today.

I really feel that from a Government point of view, if we are willing to accept that decision, this is certainly an indication of the strength of support in how we are going to get this message beyond this room that Dr. Mayer has so aptly described.

I, for one, am rather concerned about it, particularly as we go down this road to discuss this very important problem that we have.

Mr. **FROST**. A number of the carriers did take across-the-board cuts, but others made specific types of program cuts. With 126 carriers, you really have decisions made all over the map about that, but those were really made by the individual carriers and not by OPM.

Senator **QUAYLE**. Well, I will be willing to send to you and perhaps to Mr. Devine some of the statements and testimony that we have had on this, and maybe you might want to reconsider this decision because of the fact that we are really pushing forward to try to get this drug abuse and alcoholism in its proper perspective.

And since I think that you will be surprised at what the result really translates into, maybe there might be some corrective action to take if, in fact, we want to, as you state in your thing, continue Government-wide leadership in this area. To continue the Government-wide leadership in this area, I think that we are going to have to be a little bit more sensitive to the actual outcome on this particular issue.

Thank you, gentlemen.

Senator **HUMPHREY**. Dr. Mayer, can you tell us something about Secretary Schweiker's health promotion initiative as it will address alcoholism and alcohol abuse and drug abuse?

Dr. **MAYER**. Well, the initiative very importantly includes consideration of prevention activities among youngsters up through their teens with respect to the use of alcohol and drugs. This is one of the major elements in it. In fact, as a separate initiative, I believe the Secretary intends to launch a campaign specifically directed at teenage alcoholism or teenage alcohol abuse.

More than that, I cannot really spell out.

Senator **HUMPHREY**. All right. I understand it will involve a nationwide media campaign. Are those public service announcements, mostly?

Dr. **MAYER**. Yes, sir.

Senator **HUMPHREY**. In your testimony you state that NIDA will soon have a monograph available to help employees, managers, and unions develop effective prevention policies and programs for drug and alcohol abuse. When will that be available, and how can people access that?

Dr. **Mayer**. Well, NIDA has already distributed 3,000 or 4,000 copies of their monograph on developing an occupational drug abuse program, and that is available now, sir.

Senator **Humphrey**. That is available through the Institute on Drug Abuse?

Dr. **Mayer**. Correct.

Senator **Humphrey**. All right. I thought that would be worth mentioning because we are trying to communicate here. Fortunately, we are not just talking to ourselves. We have press with us this morning who will be reaching untold millions, no doubt, and we just have to keep saying these things over and over before the message finally gets through, I guess, so that is what we are doing.

What about attitudes toward drugs? You mentioned the important change in attitudes and evolution in attitudes toward alcoholism. Do you see any changes so far? It is a much newer problem, of course, but do you see any attitude changes so far in the area of drug abuse?

Dr. **Mayer**. I do not see the same kind of attitude change about drug abuse because with drug abuse, we are dealing with an illegal set of substances, whereas alcohol is legal and is widely available in our society and is a part of everyday life for a great many people without problems.

Drug abuse, however, is a totally different set of mindchanging experiences, laid over with criminal elements. So, I certainly believe that we are going to have to encourage the kind of attitude change that has led to the formation of several thousand parent groups around the country—an attitude that this is their business and that this is something that they can do something about, but not an attitude that, well, drug abuse is just a benign thing and no different from the occasional person who has a problem with alcohol. That is quite a different problem.

Senator **Humphrey**. But an attitude change in the sense that this is not just something to be tolerated or something about which nothing can be done.

Dr. **Mayer**. Right.

Senator **Humphrey**. That is the kind of attitude change we need in this area.

Dr. **Mayer**. Absolutely.

Senator **Humphrey**. And we see at least some beginnings of the change in attitude, the formation of active parent groups being one manifestation.

Dr. **Mayer**. I do not think that a comparable attitude change in the direction of minimizing the danger of the use, say, of marihuana—and, of course, that is widely proposed as something that is not really very dangerous—I do not think that kind of attitude change would be good at all.

Senator **Humphrey**. I quite agree. In that context, do you want to comment on the misperceptions that might have been created by the panel report issued 10 or 12 days ago that apparently—I have not seen it myself—but apparently recommended removal of criminal penalties with regard to marihuana?

Dr. **Mayer**. Yes, sir, I am delighted at the opportunity. I very strongly categorically oppose any change in the present Federal policy on marihuana, and I have good reasons for that. The present policy is working. There is a decline in marihuana use, particularly among our youngsters. They are making decisions for themselves that it is dangerous and that it impairs growth—at least psychological and emotional growth.

Senator **Humphrey**. Yes.

Dr. **Mayer**. They are making health decisions and they are cutting down on their use. Furthermore, increasing numbers of our youngsters themselves express the desire for stronger legal sanctions and legal constaints on the use of marihuana.

To move in the opposite direction, the direction of decriminalization—and I have heard a great many of the arguments why that should be done—to move in that direction would give a very clear signal, would it not, that somehow it really is not so bad?

I do not believe that somebody, for possession of a small amount of marihuana, ought to spend 20 years in prison. On the other hand, for us to give any indication that it is anything but what it is—a serious danger to particularly the young people of this country—to give any other message would be a terrible disservice to the citizens.

Senator **Humphrey**. Then you categorically reject the recommendations of that panel, is that correct?

Dr. **Mayer**. Absolutely. I would consider that a major defeat in public health in this country and in the world.

Senator **Humphrey**. Well, as I understand it, the panel did not really address the medical implications of marihuana use. It was addressing the effectiveness of the justice system, is that correct? It is an important distinction. They did not address the health effects of marihuana, did they?

Dr. **Mayer**. That is correct, as I understand it. Of course, we need continuously to discuss and come to sensible and thoughtful conclusions about penalties for any socially unacceptable behavior. But to say that it would be ideal to move in the direction of legalization or decriminalization is going entirely too far, in my judgment, and would, as I say, render an enormous defeat to important health progress in this country.

Senator **Humphrey**. Well, thank you very much, Dr. Mayer and Mr. Frost, for your excellent testimony this morning.

Dr. **Mayer**. Thank you, Mr. Chairman. It has been a real honor.

Senator **Humphrey**. Next, we are honored to have with us this morning the former Secretary of Health, Education, and Welfare, Mr. Joseph Califano.

Mr. Califano, I hope you were not having a cigarette break back there. [Laughter.]

No, sir.

Senator **Humphrey**. You are free to proceed as you wish. Your full statement will be included in the record. Actually, we would prefer it if you would summarize it, but in any case you are free to proceed as you wish. We are glad to have you with us.

STATEMENT OF JOSEPH A. CALIFANO, JR., FORMER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Mr. **Califano**. Mr. Chairman, thank you. I am delighted to be here.

I think these are very important hearings. At the request of Gov. Hugh L. Carey, I have just spent 18 months doing a study of alcoholism and drug abuse in New York State, with a focus on the State government, private sector and local government and what they can do. We held public hearings across New York State at which more than 130 witnesses testified. I interviewed dozens of public officials, treatment providers and others, and my staff interviewed hundreds more. The Governors of 44 States responded to my request for information about the extent of the problems faced by their States, and what they are doing about them. We commissioned 18 special expert studies. The final report was transmitted to Governor Carey on June 14, and has been reprinted by Warner Books as a mass edition paperback, with all profits going to New York State.

I come away from this study with some strong views and perhaps some helpful suggestions for this committee.

Addiction is America's No. 1 health problem. The deaths, disabilities, and diseases from alcohol, cigarettes, heroin, and other opiates, cocaine, marihuana, angel dust, valium, and other tranquilizers, sedatives and barbiturates far exceed the mortality and morbidity toll of any other illness—indeed, of most other illnesses combined.

The economic cost of addiction—health care, days away from work, and lost productivity, in which your subcommittees are interested—is well over $100 billion this year. The human costs cannot be calculated; there is no price tag on sorrow or family tragedy or life itself.

Consider the number of people involved: 50 million Americans are hooked on cigarettes, 15 million of them under 15; 13 million Americans are addicted to alcohol or abuse it; half a million are addicted to heroin. At least a million Americans abuse barbiturates and other sedative-hypnotic drugs; 53 million Americans have used marihuana at least once and 14 to 17 million cocaine at least once. No one knows how many millions of them are dependent in one way or another on those drugs.

Even considering that many individuals abuse a variety of substances and therefore show up in more than one category, the number of Americans in servitude to alcohol and drugs is frightening.

Combination drug abuse is dangerously up. Virtually all heroin addicts abuse alcohol or other drugs. There are fewer and fewer pure alcoholics who abuse only alcohol. During my tenure as Secretary of HEW, and during the course of the study for the State of New York, every alcoholic I interviewed was also involved with some other drug, usually pills like tranquilizers or barbiturates.

Of all the drugs Americans use and abuse, heroin is the most terrifying. It holds users in a tenacious grip of physical dependence. Heroin addiction spreads through urban areas like a malignant cancer. No other drug has demonstrated the same capacity to rip up a neighbhorhood, and with it the pride and aspirations of the people who live there.

But many other drugs, legal and illegal, have a serious adverse effect on health and productivity of millions of Americans. Cocaine, pot, and pills cost our society billions of dollars each year in health care, crime, employee absenteeism, and lost productivity.

The substance of most pervasive abuse is alcohol. Alcoholism is one of America's top four diseases. In the number of people it attacks and the economic toll it exacts, alcoholism is gaining fast on heart and circulatory disease, cancer, and respiratory illnesses. If we do not act now to fight the disease with prevention, treatment and research, alcoholism could be America's No. 1 disease before the end of this century—in less than 20 years.

The financial impact of alcoholism on American industry and the productivity of our work force is enormous. Alcohol-related absenteeism, employee turnover, industrial accidents, low-quality work in the office and on the factory floor, and low productivity cost employers billions of dollars each year.

Through higher prices, products that are poorly made, and jobs and markets lost because of the inefficiency of American industry, the cost is imposed, in the end, on all of us. We all pick up the tab for the three-martini lunch, and the tab is more than $60 billion a year for the United States.

The largest component of the cost that alcoholism and problem drinking impose on employers is lost productivity. Under the influence of alcohol, an employee may work too slowly, make errors that other employees have to correct, or break equipment that others need to use. All this has an adverse effect on productivity to the tune of nearly $30 billion each year.

Many employers, as Senator Quayle noted, are unaware of the extent of their own company's alcohol problems. One study revealed that 50 percent of the executives from leading insurance, banking, utility, transportation, and financial organizations believed alcohol abuse was "not really a problem" for their organization. Only 1.8 percent perceived it as "a very serious problem."

The problem is, in fact, deadly serious; 1 out of every 20 American workers is an alcoholic. If we include problem drinking as well as alcoholism, the proportion takes a big jump: to 10 percent and perhaps even higher. The savings from doing something about it are big.

The General Accounting Office estimates that alcoholism among the nearly 3 million Federal workers costs the taxpayers $700 million each year. If half the alcoholics employed by the Federal Government were successfully treated, the annual savings to the taxpayers would be $347 million a year. Business can also realize big savings by facing up to the problem.

What can we do about alcoholism and drug abuse in the work force? The key, as Dr. Mayer noted, is early intervention. Early intervention is a technique for spotting individuals with alcohol and other drug problems, pressing them to recognize the problem, and making it easy for them to find help.

Early intervention programs can reach millions of Americans at work. When the alcoholic or drug abuser is identified while still working, the prospects for successful treatment are greatly enhanced. Employees' group health insurance plans can provide a way to pay for treatment. Though employers typically bear a substantial share of the insurance cost, they can expect handsome dividends in reduced absenteeism, lower medical costs, increased productivity, decreased termination and replacement costs, and higher employee morale.

Over the last decade, a considerable number of American companies and unions have established work place early intervention programs. Commonly known as employee assistance programs, they grew out of 40 years of trial-and-error experience. Initial programs tended to concentrate on alcoholism rather than other drug- and job-related problems. They missed large numbers of employees in need of help, including many alcoholics.

Except in extreme situations, supervisors were reluctant to make a diagnosis of alcoholism. Without that diagnosis, the employee fell outside the scope of the program. Gradually, programs became more sophisticated. By the 1970's, many were concerned with pills, pot, and harder drugs as well as alcohol, and with other personal, social, and health problems. Today, the best programs attend to all aspects of deteriorating job performance.

Most employee assistance programs follow a similar pattern. With few exceptions, they provide no treatment for alcoholism or drug abuse, but rather refer the employee to an outside facility. Many employees go to a program on their own before they are threatened with dismissal; some do not. So, where necessary, trained supervisors and union stewards should be prepared to confront employees about deteriorating job performance while at the same time offering help through the company program.

The importance the alcoholic attaches to his or her job can be critical. For many alcoholics, the job is more than just a source of income. It is an essential beam in the framework of self-deception they construct to hide their drinking problems from themselves as well as others. "If I were an alcoholic," they say, "then I could not hold down this job." The threat of job termination can spark a crisis in the alcoholic's life and create the motivation to seek help through the employee assistance program. The same technique can work for abusers of other drugs.

With the aid of supervisors trained to notice the first signs of deteriorating job performance instead of waiting for clear symptoms of alcoholism or drug abuse to emerge, a well-run employee assistance program can get alcoholics and other drug abusers into treatment many years earlier than would otherwise be likely.

Reported recovery rates for alcoholics referred to treatment through employee assistance programs range as high as 90 percent and, in any good program, should be above 50 percent. The New York City Police Department effort, under the direction of the department's recently retired chaplain, Monsignor Joseph Dunn, recorded a recovery rate of 75 percent. Since 1966, 2,000 police officers have recovered and returned to full duty with firearms.

I notice you have representatives from General Motors from Indiana testifying here this afternoon, and also representatives of the UAW. Dr. Nicholas Pace, the medical director of General Motors' New York office, testified at our hearings in New York that between 1972 and 1979, almost 42,000 GM employees—some 7 percent of its North American work force—were involved in the company's employee assistance program.

More than 60 percent of them had alcohol problems; another 14 percent were involved with other drugs; the remaining 22 percent with other health or family difficulties. For the 42,000 workers who went through that program, time off the job declined by 40 percent and sickness and accident benefit payments dropped by 60 percent. GM also found that accidents on the job, management disciplinary actions and employee grievances were cut in half for the treated group.

Kennecott Copper Corp.'s employee assistance program reduced absenteeism for employees treated for alcoholism by 50 percent. In Baltimore, a group of employees joined together to sponsor an alcoholic treatment program, in a consortium of the kind mentioned by Dr. Mayer. The impact: a $586 saving per employee in reduced absenteeism in the first year. Other companies report savings of more than $1,000 in reduced absenteeism in the first year.

Direct health care cost savings are also substantial. Estimates of reductions in inpatient medical care costs range from $300 to more than $600 per employee per year. The Illinois Bell Telephone Co. reported savings of more than $1,000 per treated employee in lower sickness and accident disability payments. As Kennecott Copper, hospital, medical, and surgical costs for the treated group dropped by 48 percent. Treatment has also resulted in sharp reductions in the use of health care services by members of the treated alcoholic's family—something we often forget.

There is a wide variation in the reported ratios of benefits to costs for employee assistance programs. They range as high as $20 returned for each dollar invested, but none are below the break-even point. The differences are attributable to differences in the grality of programs as well as differences in the variables measured.

The growth of employee assistance programs has been impressive during the 1970's, but there is real basis for concern about where we go from here, which makes these hearings very timely.

Most if the increase came in the first half of the decade. The growth rate dropped between 1976 and 1979. Moreover, programs are concentrated in big companies. As we enter the 1980's, only 12 percent of the Nation's work force has access to an employee assistance program.

Most of the labor force is employed by businesses too small to support the kind of employee assistance programs that have proved successful for larger employers. A firm with 10 to 15 employees--a small law firm, a group of doctors, a retail store--is unlikely to find it profitable to hire even a part-time consultant to run its own program. For small businesses and the millions of individuals who work in them, joining together in a consortium holds great promise.

In a consortium, a group of small firms share resources so their employees can take advantage of early intervention and referral services. The consortium is ordinarily built around an independent center that serves a number of small businesses in an area. The center develops policies and procedures and trains people. It conducts sessions for supervisory personnel of its small business members, receives employees from member businesses, and refers them to appropriate treatment facilities, and arranges for followup and after-care.

If employee assistance programs work so well, why don't more companies have them? In a survey of managers whose companies have no such program, 78 percent said they did not believe such programs would save their companies money. More than 90 percent reported that their companies did not have a serious problem with alcoholism or alcohol.

The stigma associated with alcoholism discourages some companies from setting up early intervention programs. They just do not want to admit to the public that they have drunks working there. Too many executives still believe in their hearts that alcoholism cannot be treated and that their obligation to shareholders and customers is to get rid of alcoholic employees, let them find work somewhere else.

Many managers base their belief that they have no serious alcoholism problem on their employee selection procedures. They assume that alcoholics are screened out during preemployment interviews. What they fail to appreciate is that alcoholics in early or middle stages of the disease are very difficult to identify. Many have a degree of control over their drinking and behavior and will not be viaibly intoxicated during an employment interview.

Experience with alcoholics in a number of diagnostic settings indicates that only the most expert and experienced interviewers are likely to penetrate the shield of denial and deception that protects many alcoholics from accurate appraisal by others. Besides, drinking problems may arise after an employee is hired.

Another common barrier to establishing employee assistance programs is the absence of a way to finance treatment. Where insurance coverage for treatment of alcoholism and drug abuse is inadequate, which is often the case in group health insurance plans, managers may be unwilling to adopt a program. They know they can get coverage for alcoholism and other drug addiction, but fear that coming on top of already expensive health insurance policies, it would unacceptably increase costs.

In fact, we found in New York that adequate coverage is not very expensive. Premiums for extended alcoholism benefits are usually less than a dollar a month for each covered individual. In 1982, Blue Cross of Northeastern New York charges approximately $0.80 for a covered employee, and $1.65 a month if dependents are also covered, for comprehensive benefits that cover treatment not only for alcoholism but for drug abuse generally.

For a large group, where administrative costs are lowest, in New York the Metropolitan Insurance Co. charges about $.75 a month for inpatient treatment and $0.12 a month for coverage of outpatient care. Because some alcoholism treatment claims are already being paid under its standard hospitalization plan, even without the rider, the Metropolitan reduces the in-patient cost by 50 percent where it provides hospitalization coverage as well. For its optional alcoholism package, Aetna Life Insurance Co., monthly premium in 1981 in New York ranged from $0.38 to $0.60 for each individual covered.

To persuade managers to adopt employee assistance programs for their organizations, we must present them the facts about alcoholism—something you are trying to do, Mr. Chairman, in this hearing—and drug abuse in the work place, how much it costs their organizations, and what they can do about it. Above all, they must come to understand that establishing an employee assistance program is a good investment as well as a humane and responsible way to deal with their employees' problems.

Business and union leaders who have seen what these programs can accomplish should help persuade their skeptical colleagues of the benefits they can deliver and of their moral and social obligations to help their employees.

Government at every level should set an example by maintaining effective programs for their own employees. In New York, the State government—the State's second largest employer—has the best record to date. Most States lag far behind New York. Municipal and county programs in that State need to be expanded, as they do across the country, as do programs for Federal employees.

Government can do more than just set a good example. It can provide a focal point for a major effort to expand these programs. States can set targets for expanding the reach of programs in the private and public sectors. In New York, for example, I recommended a goal of doubling by 1985 the proportion of employees with access to an employee assistance program.

States can act as organizers, informers, and leaders. They can provide financial help to small businesses to encourage them to join in consortia to operate programs.

As everywhere else in the fight against alcoholism and drug abuse, the Federal Government should play a leadership role, contributing technical expertise, resources, and a sense of commitment to help spur the private sector to act.

We must move promptly with early intervention programs in the alcohol and drug area. The tragedy with alcohol is that we know these programs can be effective. Detoxification, followed by a month of residential treatment, then return to a job and a home with a supportive and loving spouse, family members, or friend, along with contract with Alcoholics Anonymous, will restore alcoholics far more often than not. With alcoholism, we know enough to save millions of lives over the next several years. Whether we do so depends on our willingness to act and to commit the resources needed to treat these people.

With heroin, other drugs, and combination drug abuse, we are not nearly so far along in our knowledge of how to deal with addiction. We must invest our money and our best minds in seeking biomedical and psychological treatments for addiction generally. This means continuous, ample funding sufficient to take advantage of research breakthroughs whether expected or serendipitous. For this research, I believe we should create a national institute of addiction within the National Institutes of Health. Such an institute would focus on all addiction—alcohol, cigarettes, heroin and other opiates, pills, marihuana, all drugs licit and illicit and, as it became more sophisticated, with some of the difficult habituation problems that people face—obesity, compulsive gambling, and the rest.

With strong leadership from Washington to spur the establishment of early intervention, treatment, and prevention programs, particularly with support for research on all forms of addiction, we can make unprecedented progress in dealing with addiction, all across America, reducing its savage human toll and enormous financial cost.

Thank you, Mr. Chairman, for inviting me to participate in this important hearing.

Senator HUMPHREY. Thank you, Mr. Secretary, for an excellent statement. We are privileged to have you with us this morning.

You noted correctly that employee assistance programs are a good investment. Yet, you also noted that in a survey of companies without such programs, 78 percent did not believe or were not aware that such a program could save them money. If people who deal with sound business decisions day in and day out—bottom-line kinds of decisions—if they are not aware of it at this point, how in the world are we going to make them aware that it is a good business—putting aside all the humanitarian concerns, if necessary—but it is a good business decision to have such a program? How are we going to get that message out there?

Mr. CALIFANO. Well, I think, Mr. Chairman, that the health problem—health care and health insurance for employees—has not really been in the mainstream of the American businessmen's life until recently. Basically, they are producing products; they are trying to get their products out at the lowest cost with the best quality.

With health care costs now rising so high, our corporate leaders will pay more attention to them. Our big companies, certainly, like General Motors and some of the other auto companies, are paying more attention to them. As they focus on health care costs, they may face up to the role of alcoholism and drug addiction in driving up those costs.

For the small businessman, it is much more difficult, as I indicated. There, the Government may have to do more than provide information. Whether at the Federal, State or local level, government may have to help seed some of these consortium programs to get them started.

Senator HUMPHREY. You state in your testimony that the Government—and I assume you mean here the Federal Government—can do more than just set a good example. It can provide a focal point for a major effort to expand employee assistance programs.

You have just given one example of how the Government can act as a focal point by providing seed money. Where we get it is a thorny problem, but do you have other ideas? Can you expand on this suggestion that Government should act as a focal point?

Mr. CALIFANO. I can offer several examples that would not cost much money and would have a significant pay-off.

The Secretary of Health and Human Services could get his counterparts from the State governments and some large local governments into a conference. One day is all you would need to get them started setting goals in their States and encouraging better insurance coverage for alcoholism and drug abuse.

The same kind of effort could be made with business and labor leaders. They will be responsive to the Secretary's leadership. We had a conference on health maintenance organizations for business corporations when I was Secretary and, to my astonishment, my recollection is that 675 of the major companies came in to spend 2 days because they were so concerned about health care costs.

I should add that the Federal share of financial support for alcoholism treatment has gone way down over the last 5 years. In New York it has gone from 35 to 14 percent in just 5 years. The State and local shares have gone way up. In New York, the State's share is now up at about 65 percent. The States are really at the cutting edge of the operational effort right now.

Senator **Humphrey**. To what extent is prevention a part of these employee assistance programs?

Mr. **Califano**. It is a part in the sense that they try to move back earlier and earlier in the hope of reaching those who are abusing alcohol but are not yet addicted.

Senator **Humphrey**. Yes.

Mr. **Califano**. The personnel departments of these companies can provide preventive services. My own view on prevention is that the place to focus the effort is on the last 2 years of elementary school and the 4 years of high school. And it should cut across the entire health area, covering alcohol, drugs, cigarettes, and general health promotion.

Why? Because the peak years for heroin addiction are 17 and 18. Virtually nobody becomes addicted to heroin after they are 28 or 29 years old. Cigarettes follow almost the same pattern; 75 percent of the people who are addicted to cigarettes are addicted before they are 21.

Alcohol abuse patterns that start as heavy drinking on the weekends, getting drunk every weekend, and eventually swinging over to alcoholism, start in high school. We have good models for school-based prevention programs. Government should concentrate its prevention efforts—and invest the necessary resources—in helping schools get such programs established.

Lastly, we know those programs work. The cigarette programs of the late 1970's taught us that we can discourace hazardous practices through education and prevention. We know that drug abuse programs work in high schools, and we know that alcohol programs work.

Senator **Humphrey**. Thank you very much. Senator Quayle?

Senator **Quayle**. Thank you.

Mr. Califano, it is always a pleasure to have you on the Hill. You are animated and knowledgeable and insightful on a very important topic.

Looking at the book, the official report to the Governor of New York, you have a little bracket up here that says, "Addiction is America's No. 1 health problem." Yet, in your survey with management people, I think you said 90 percent said they did not have a serious problem in this particular area. What gives?

You are right; addiction is America's No. 1 health problem. Yet, 90 percent would give you a response that it is not a serious problem with them. It has to be; I mean, it absolutely has to be. So, there is a fundamental problem that we have in convincing the American public that this is our No. 1 problem.

Mr. **Califano**. Absolutely.

Senator **Quayle**. We are not even close, with those statistics.

Mr. **Califano**. We are not close. That's why hearings like this are helpful and very important.

A considerable part of the problem is that most people do not relate other diseases to the addiction that causes them. The level of heart disease and cardiovascular disease that is truly related to alcohol or cigarette smoking, for example—and the same is true with respect to cancer—those relationships are not really perceived. An employer knows that employee had a heart attack, but he doesn't know, or tie it into the fact that, the employee had been drinking too heavily for the last 3 or 4 years.

Second, most businessmen do not notice these problems until they are far along and, as Senator Humphrey mentioned, they do not relate them to their costs. They do not sit down and add up what they are paying for addiction and its consequences.

They should also recognize, and this is one of the things that surprised us when we did the study in New York State—that there's a tremendous drop in the health care benefits used by the family of an alcoholic when the alcoholic is treated successfully.

Senator **Quayle**. Many people just really want to dismiss this as not a serious problem. Is that not basically the case? Is it not somebody else's problem rather than their own?

Mr. **Califano**. Well, it is somebody else's problem, except I think you would be hard-pressed to find an adult American who did not have a friend or relative with an alcohol problem, or who had had one.

There is a serious stigma problem. And it doesn't just affect businessmen. I know you have the President of the AMA testifying here later today. Physicians have a lot to do here, too. They do not like to put into the medical record the fact that a patient is an alcoholic

The general practitioner physician is not well enough trained to identify alcoholics at an early stage. He is not well enough connected often with the nonphysician part of the alcoholic treatment health care system.

Senator **Quayle**. I am told that about 40 percent of the emergency room cases that we have are related to alcohol and drug abuse, and the proportion of alcohol and drug abuse in in-patients can vary from, say, 25 to 60 percent. Yet, it is stated that oftentimes these patients are not diagnosed as being alcoholics or drug addicts to receive treatment for this, which perhaps goes to another aspect and that is the whole health care system that we have, or the failure of that system to identify this problem when these people come into the hospital, whether it is emergency or in-patient. Have you found this to be the true case?

Mr. **Califano**. Yes, Senator, we have, and I think you raise and put your finger on a very important point. In New York where we looked at this problem at least 20 and perhaps 40 percent of all patients seen in hospital emergency rooms are alcoholics or problem drinkers. Counting all admissions related to alcoholism, alcohol abuse and drug abuse—including accident and crime victims—the proportion is much higher. Fully half of the beds in the public hospital system of New York City are filled with people who have alcohol or drug problems.

Yet, most of them are not identified going in and they are not treated. Their cirrhosis of the liver is treated. The physical damage from the automobile accident is treated, but nothing is done about the alcoholism. Alcoholism treatment has got to become a central part of the health care system. Doctors have to be better trained.

I will give you a personal example of a couple of months ago. I was talking at the Grand Rounds of the Boston City Hospital and Harvard Medical School. There must have been 300 interns and residents there, and at the end of speaking to them and taking a lot of questions, I said, "You have asked me all these questions. What are the major problems you see with health care? If you could do something, what would you do?" A woman intern was the first one to speak, and she said, "I would deal with alcoholism." The whole room burst into applause.

These are the young residents and interns who are out there every day in those hospitals dealing with the people coming into the emergency room.

Senator **Quayle**. What convinced New York to undertake this program? Were there any particular factors in that State for why they appear to be ahead of other States?

Mr. **Califano**. Well, New York has the most severe heroin problem in the country. The number is stunning when you think about it. One out of every 40 people in New York City is a heroin addict. That is what initially got Governor Carey interested in the problem of drug abuse.

As we began to look at drugs a little bit, it became apparent that as devastating as heroin is—half a million addicts in the country; 234,000 of them in New York State, and 177,000 of them in New York City—alcohol was a far more pervasive problem in terms of the numbers of people involved and the people it touched. That is how we got into this study.

Senator **Quayle**. So, it was just the outstanding number of people on heroin which was——

Mr. **Califano**. That initially sparked it. New York City is the heroin capital of the United States. Most of the heroin comes in through that city and it has a terrible problem.

But having said all of that, alcoholism is a far greater problem in terms of the cost to the State of New York, in terms of the numbers of people involved, and their families, and the cost to the country.

Senator **Quayle**. Well, thank you very much for your testimony and the publication of your book. I certainly am interested in this area and, more particularly, the impact on productivity and convincing people in business and labor. Many are doing a very good job, but we have got to expand it beyond the 10 or 12 percent that are currently picking it up.

I certainly look forward to communicating with you in the future on this issue that we mutually perceive as very, very critical to our Nation's health.

Mr. **Califano**. Thank you very much, Mr. Chairman. It would be my pleasure.

Senator **Humphrey**. Senator Pell?

Senator **Pell**. First, I would like to congratulate Senator Humphrey and Senator Quayle on holding this hearing, on their choice of subject matter, and on organizing it as a joint hearing. I have always believed that the more joint hearings, the better. It means that the subject matter is discussed more widely, and I just congratulate you both on that.

I am particularly glad to be at this session with Joe Califano, with whom I have had the good fortune to work for many years. I regretted his departure when he left the Government. I think the Government was much richer for his services when he was in it, although he is much richer for being out of it. [Laughter.]

Senator **Pell**. I have gotten particularly interested in alcoholism and drunk driving because two of my staff members were killed within one 6-month period by drunk drivers, and in each case the drunk driver got a tap on the wrist and is driving around now as if nothing had happened.

Also, my State has one of the highest rates of alcoholism of any State; why, I have not been able to figure out. I would be very interested in your thoughts as to why, because we know this condition exists. It may be partly a question of our heritage.

I remember that when I was a young boy, we were the 1 State that had not ratified the Hallstead Act out of the 50. So, we have a long tradition of alcoholism in our State. I remember the principal bootlegger in town when I was a boy was right next to the police station, so the laws were not very arduously enforced there.

In connection with the work that you did in this excellent study, I was just curious whether you believed that the employee assistance programs really can help in dealing with the problem of drunk driving, or are these make-work projects, in your view?

Mr. **Califano**. No. Employee assistance programs will help with the drunk driving problem because they will help curb alcoholism and alcohol abuse. The workplace has almost unique advantages as a setting for early intervention. It is often very difficult even for family members to do the kinds of things that have to be done to make an alcoholic confront the problem, to push them hard to the kind of treatment they need.

Senator **Pell**. You cannot push them. You have to lead them.

Mr. **Califano**. An employee assistance program can do things in that area that even family members cannot do.

Will it affect the drunk driving situation? Yes, it will because it will reduce the number of people abusing alcohol who are alcoholics and who are sitting behind the wheels of cars.

Senator **Pell**. We have got a very good drunk driving bill in the Senate, I believe. Senator Danforth has taken a leading role in it, and hopefully that will get acted on with the House this year, and then hopefully the President will sign it. But there are still two hurdles to overcome.

Did your study for Governor Carey review any examples of the impact of alcohol in the workplace on the families and coworkers of problem drinkers?

Mr. **Califano**. Yes, it did. The study indicates that if you successfully treat the alcoholic, the health care problems of the alcoholic's family will be reduced. At least the benefits that they use from health insurance policies go down significantly, so it does have a salutary effect there.

Not from New York State and any surveys we did as a matter of original work there, but from papers we reviewed, it is also clear that where the alcoholic is a parent, treating the alcoholic successfully will have an impact on the child's performance in school and the whole mental stability of the child. One of the things that really hit us hard in the study was the fact that if you are the child of an alcoholic, you are four times more likely to be alcoholic when you grow up than if you are not the child of an alcoholic.

Senator **Pell**. What would be your definition of an alcoholic? Is it one who succumbs——

Mr. **Califano**. I am not a doctor and I will defer to the AMA, but by and large—and I am sure this is oversimplified—it is someone who is dependent on alcohol or who is addicted to alcohol.

Senator **Pell**. Because of the impact of alcoholism on the payouts of insurance companies, I would think they would be particularly interested in programs of this sort that you have described. They have an economic stake in it, what is more, and they should help smaller companies particularly to develop programs along these lines.

What has been your experience?

Mr. **Califano**. The insurance costs of riders that cover alcoholism adequately are not high—say, $1 a month per person, not more than that, and less for dependents.

In fairness, I have to put one caveat there. In many States—some States, you know, have mandated that group insurance policies provide alcoholism riders; some States have mandated that companies at least offer the option—in many States, those riders have not been used as frequently as one might have expected. It is difficult to tell why, and a large part of the reason why may be that when a physician is treating an alcoholic, he is very much inclined not to identify him as such, even if he is giving him a course of treatment for alcoholism, because of the stigma attached.

These riders are important. It is hard enough to lead the alcoholic, as you say, to seek help, but when you add to it the fact that one of the critical components of help—a month or so in a residential rehabilitation center—is very expensive—$5,000 to $10,000—it is obvious why adequate insurance coverage is so important.

Senator **Pell**. What happens when a man or woman completely dependent on alcohol goes to jail for 1 year and has no alcohol? Do they emerge still alcoholic, or have they been cured by that so-called cold turkey treatment?

Mr. **Califano**. You touch on another subject dear to my heart, Senator, in the context of that report. Nothing is likely to happen, except that that person is likely to go back on alcohol. Is it a problem? Yes.

We think of our prisons today as full of Jimmy Cagneys and Humphrey Bogarts and George Rafts, but those prisons exist only on celluloid today, if in fact they ever existed. Today, about half of the populations in State and Federal prisons are alcohol or drug abusers.

In New York State, two-thirds or more of the State prison population of more than 25,000 are alcohol or drug abusers. It is preposterous to put somebody in prison in that situation and not provide any treatment. New York State provides treatment for less than 4 percent of those people; most States not even that. And then they come out and, of course, they commit crimes again. They go right back on alcohol or drugs.

It's like sending a cancer patient to Sloan-Kettering, putting him in there and not giving him any therapy—not operating, not giving him any radiation. And then condeming him as a recidivist for going back to the hospital, shortly after his release, with worse cancer.

The prison system is a preposterous anachronism in this country. It is full of alcoholics and drug abusers who are not being treated.

Senator **Pell**. The strange thing is that we say in order to cut down crime, we ought to have more and tougher prison sentences. Yet the fact of the matter is that we have more people behind bars on a percentage basis than any other so-called free world nation, except for the Union of South Africa.

This, to my mind, is quite a horrifying statistic because it shows that whatever it is that is causing the crime is more endemic in our Nation than any other nation, and yet we are rather proud of our civilization.

Do you think perhaps the reason for it is because we may have a higher rate of alcoholism than other nations?

Mr. **Califano**. I cannot off the top of my head answer that question. I think we do need tough laws and I think we do need tough prison sentences. If you take something like drunk driving, it is quite clear that tougher laws, tougher sentences, including jail terms, and higher fines, have had an enormous impact on the rate of drunk driving arrests and accidents and deaths in the States that have put them into effect.

Senator **Pell**. We passed one of the toughest laws in Rhode Island. It has already had an impact in a matter of weeks.

Mr. **Califano**. My point is that if the person sent to prison for committing a crime is a heroin addict, for example, or an alcoholic, and we do nothing while that person is in prison to deal with the heroin addiction or the alcoholism, we are virtually guaranteeing that the person will be back on alcohol or back on heroin after release, and therefore back into the kinds of crimes; that were committed before—with heroin, usually property crimes, with alcohol, more often crimes of violence.

Is there a crime problem associated with alcohol? Emphatically, yes. Alcohol is involved in two-thirds of the country's homicides, up to 50 percent of the Nation's rapes, and 70 percent of the assaults in this country, and 50 percent of the child molesting. So, yes, alcohol is a serious problem in the crime area as well.

Senator **Pell**. From the viewpoint of drugs, I guess alcohol is the one that is the most harmful. If people smoke too much or they take heroin or marihuana, that does not necessarily lead to crimes, except to secure the heroin, but alcohol leads to the actual commitment of crimes.

Mr. **Califano**. I think that is true with respect to marihuana and cigarettes. I would note, though, that with respect to heroin, heroin spawns an enormous amount of crime. It probably spawns 100,000 crimes.

Senator **Pell**. But that is to get the heroin.

Mr. **Califano**. To get it, but those are burglaries, robberies, purse snatchings, and that does not even count the petty theft. Violence is often associated with these crimes, for example, when an addict is in your home and you accidentally find him.

Senator **Pell**. But the heroin addict himself does not commit a crime, except to get money to satisfy his urge. Is that correct?

Mr. **Califano**. He is more likely to be involved in property crime.

Senator **Pell**. With the high or low, or whatever it is, with heroin, you do not go around with an ax; you are in a blissful state.

Well, thank you very much indeed. One other thought on the jails; as you know, jail is very expensive. It costs, I think, two and a half times what it costs to send a young man to Harvard today to keep him in a prison.

So, I would hope that we succeed in what you are trying to do, which is to reduce alcoholism. That will reduce the burden on the taxpayer to a remarkable degree.

I thank you for being with us and wish you well, Mr. Secretary. I only wish you were still in the Government and I hope you come back.

Senator **Humphrey**. Thank you very much, Mr. Secretary.

Mr. **Califano**. Thank you, Mr. Chairman.

Senator **Humphrey**. The next panel is comprised of Mr. Peter Bensinger, former Administrator of the Drug Enforcement Administration; Mr. Ed Small, president of the Association of Labor-Management Administrators and Consultants on Alcoholism; Dr. Madeleine Tramm of the Amalgamated Clothing and Textile Workers Union; Dr. William Rial, president of the American Medical Association; and Dr. Burford Culpepper of the Du Pont Corp.

Good morning, and thank you very much for your patience. Let us begin from left to right with Mr. Bensinger, and may we ask that, owing to time constraints, you summarize your statements? The full statement will be included in the record.

Mr. Bensinger?

STATEMENT OF PETER B. BENSINGER, PRESIDENT, BENSINGER, DuPONT & ASSOCIATES, INC. AND FORMER ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION; EDWARD J. SMALL, NATIONAL PRESIDENT, ASSOCIATION OF LABOR-MANAGEMENT ADMINISTRATORS AND CONSULTANTS ON ALCOHOLISM; MADELEINE TRAMM, DIRECTOR, HEALTH ASSISTANCE PROGRAM, AMALGAMATED CLOTHING & TEXTILE WORKERS UNION; WILLIAM Y. RIAL, PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY LeCLAIR BISSELL, MEMBER, PANEL ON PHYSICIAN MORTALITY AND PANEL ON ALCOHOLISM, AMERICAN MEDICAL ASSOCIATION; AND BURFORD W. CULPEPPER, ASSISTANT MEDICAL DIRECTOR, E. I. DU PONT DE NEMOURS & CO., ACCOMPANIED BY JOHN F. DICKEY, LEGAL DEPARTMENT, E. I. DU PONT DE NEMOURS CO., A PANEL

Mr. **Bensinger**. Thank you very much, Chairman Humphrey, Chairman Quayle. I am pleased to be joining this important hearing today, and I will summarize my remarks and certainly make myself available for questions.

Senator **Humphrey**. Fine.

Mr. **Bensinger**. You will hear from many of the panelists on this panel and thereafter—and Joe Califano made reference to it—of some programs by companies and unions that work—some examples of management that recognize it, unlike the 88 percent that Senator Quayle was talking with the Secretary about that have not developed an important employee assistance program.

This is no small assignment. We are talking about $20 billion of lost productivity, accidents, absenteeism, treatment costs. We are talking about serious personal implications to the individual employee and to that employee's family—a tragic situation for too many individuals.

A third of teenagers get exposed to drug use just after they turn 11. Take the 18- to 25-year-old segment of our population; 36 percent of that group uses marihuana at least once within a 30-day period. In the same age group, 18- to 25-year-olds, you have a 1 out of 5, 20-percent ratio, using cocaine within a year. We are talking about an $80 billion a year national illicit drug at retail problem, and a situation in which, in the State of California, 1 out of 6 drivers arrested for unsafe driving were under the influence of marihuana.

There are 25 million regular marihuana users; 4 million regular cocaine users—10 million using cocaine within an annual period, and almost an equal number, perhaps 7 million, regular prescription pill abusers.

These estimates that have been done by studies commissioned by the National Institute on Drug Abuse are probably conservative.

What can companies, the Senate and the country do? I think a number of steps need to be taken. The health hazards are clear; they are better defined today than they were half a dozen years ago, particularly on the health hazards of marihuana and cocaine.

Companies have to recognize the need for a policy. I am going to address myself just to what a private industry can do. Communicate it—that policy—effectively; train supervisors as to what to look for—not to make them diagnosticians or medical experts or psychologists, but just assure that they notice changes in behavior.

For a supervisor, whether that supervisor is on an aircraft carrier, a supervisor in an assembly plant, an office supervisor in a building or a warehouse or a coach on an athletic field—look for certain signals, certain gross indicators, some warning signs, and determine whether the person is really fit to do the job. That is basically the question; not to make a medical determination, but in their own mind as a supervisor, does that person seem able to carry out their assignment? If not, they should refer that individual to appropriate medical referral and help.

I think fitness for duty needs to be enforced in the workplace. It needs to be enforced in Government; it needs to be enforced everywhere. I think supervisors have that responsibility to their employers.

I think companies that employ individuals—and they do specify many times that individuals will be in a condition to do their work—have to require that. There has to be good law enforcement liaison. I think this is important. The law enforcement resources have been further reduced, so have the prevention resources, unfortunately. But it is going to be important for companies to reach out to the law enforcement and prevention community to make sure they inform law enforcement if there are violations of the law.

There is a need for screening, I think, both for pre-employment and in the case of nonfitness for duty, referral for medical review for potential problems on the part of employees. I believe you will find that companies that are not addressing themselves to this problem—and not providing employee assistance programs that you asked Secretary Califano about—may not be doing this for several reasons.

One, the issue is not high enough in the corporate structure, at the presidential or chairman's level. These problems usually surface at the personnel department which are generally not centralized, but decentralized, in plants and facilities and warehouses.

Two, there is not enough collection of the indicators of abuse problems, theft, absenteeism, loss of raw materials, law enforcement interest, turnover, quality problems. Those all show up eventually in one way or another on a balance sheet, and they may translate into alcohol or drug abuse, but they are not collected, generally, nor reviewed in individual situations that are brought to the attention soon enough of top management.

Some companies feel that putting out a statement is enough and that there is not a need to go into a major training program for safety and health, nor to launch major prevention efforts sharing health information.

Finally, I think because of the economic condition, when depressed, EAP programs tend to become optional and deferred and put off. Of course, that is a very unsound decision because the company's investment in its people is compromised, as is its investment in its product quality, its corporate reputation, and its plant and equipment.

One step that I think can be taken besides recognizing that companies need to have better awareness of this problem is that no one has the civil right to violate the law. Here, I am talking about illegal drugs. There is, I think, a need to recognize that what individuals do off-duty can affect how they perform on the job. This becomes a gray area; many times, companies do not want to address it, but I think it is important.

Someone that may get high, whether it is on alcohol, marihuana, amphetamines or barbiturates, and shows up for work does not have the right not only to violate the law, but to compromise the safety and the health not only of himself as an individual, but of the plant, the equipment and the other associates that this employee is working with.

I do believe companies can refer questionable fitness-for-duty situations for medical examination, including urine tests. I believe this has been supported by the law both at the State level and the Supreme Court level. I do not think however that this is a panacea. I do not think it is the only treatment that will work, just threatening a urine examination.

I think, clearly, you need to have health, education and safety information for all employees, and on a credible, logical, carefully explained basis, and also resources for help. The objective is to get drugs out of the workplace. One way to do it is to give individual employees a place to which they can turn to get help, and I think company investment in that kind of a program will pay off.

Some companies will address this problem in a passive way, and may get through the mine field of alcohol and drug abuse without harm, but the odds are against that happening. There are just too many drugs available. The society which we are looking at today is subject to continuing, widespread availability of drugs, reduced prevention, and in many cases reduced law enforcement resources. I do think the need on the part of private industry is urgent.

I would be happy, Mr. Chairman, to answer any questions, and would conclude my testimony with only a recognition in a positive way of this hearing and of the individuals that you have invited apart from myself, obviously, to address themselves to this problem.

Senator Humphrey and Senator Quayle, I also want to indicate my appreciation of the efforts that you have provided in changing the odds on behalf of the public against drug traffickers through legislative efforts that were passed in the last 2 years in this Congress.

[The prepared statement of Mr. Bensinger follows:]

TESTIMONY OF PETER B. BENSINGER, PRESIDENT,
BENSINGER, DuPONT & ASSOCIATES, INC.
(FORMER ADMINISTRATOR OF THE DRUG ENFORCEMENT
ADMINISTRATION, 1976-1981)

Presented to Senate Subcommittee on Alcoholism and Drug Abuse,
Senator Gordon Humphrey, Senator Donald Quayle, Co-Chairmen,
July 14, 1982.

Chairman Humphrey, Chairman Quayle, members of the Committee, I appreciate the opportunity to appear before you today to discuss a very serious problem. The Senate has taken important action by addressing itself to drug enforcement, providing clarification of the "posse commitatus" statute, repealing the funding restriction on foreign aid for herbicide eradication using paraquat, and giving attention to the Freedom of Information Act and the serious and continuing failure of our present bail structure. I hope that the House will act on the latter two pieces of legislation to increase the likelihood of a meaningful deterrent for drug traffickers.

One result of this burgeoning drug traffic is that it has sapped America's productivity. Clearly and without question, the cost to industry as a result of drug abuse has been grossly underestimated and generally not well addressed. There have been exceptions, and many of the panelists here today will describe how their companies and unions, management and employee assistance teams have worked to limit drug abuse on the job. This is no small assignment. It is costing industry, according to the American Council on Marijuana, 20 billion dollars a year in lost productivity, wages, and treatment costs.

One-third of Americans between the ages of 18 and 25 have used marijuana within the last 30 days, and one out of five of this age group has used cocaine within the last year. The U. S. drug traffic is estimated to generate 80 billion dollars of illicit revenue. In one California study, 16 percent of drivers arrested for unsafe driving were under the influence of marijuana. While there are over 25 million individuals smoking marijuana on a regular basis, and over 10 million using cocaine, almost an equal number are abusing prescriptions--and these figures are probably conservative.

What can management do to deal with the reality of drugs that are widely available and widely abused? The criminal justice system has not yet effectively deterred traffickers. Our prevention systems have not as yet effectively made clear the health hazards to users. And the health hazards are clear, much clearer than they were several years ago, particularly in the case of marijuana and cocaine. What needs to be done?

Industry must set a clear policy on drug abuse, alcohol and illicit narcotics. It must communicate this policy effectively to the employees. The policy must be supported by management and then enforced. Supervisors must be trained to be aware of symptoms that could be caused by drug abuse but that in effect render employees questionable in terms of fitness for duty. I am not suggesting a training program to make shift foreman diagnosticians, psychologists or medical experts, but simply to notice changes in behavior, to notice people not functioning safely or normally. And it is their responsibility, whether it is the loss of a night's sleep, alcohol or illicit drugs that has caused this behavior--it is the supervisor's responsibility to intervene and to find out what is going on, by addressing himself, with perhaps another supervisor, to this uncharacteristic behavior. The supervisors need training and they need the support of management. After determining that an employee is not fit for duty, a medical review is appropriate. And that medical review can and should, in many cases, include a urine test so that the employee can have a proper diagnosis as to just what may be causing his erratic behavior. The company and its supervisors must focus on job performance and fitness. Medical experts with confidentiality can make an assessment as to what is causing this behavioral problem. The Supreme Court has upheld that ... an employer can prevent, can refrain from hiring, and can in fact dismiss individuals utilizing narcotics, including those on methadone. In Illinois, the State Supreme Court ruled in favor of the Chicago Transit Authority that urine testing and blood tests could be applied by the CTA to employees after accidents or after a demonstration of aberrant or questionable behavior. This decision, I might add, was challenged by the local union, but found to be appropriate and legal by the Illinois Supreme Court, and today in Chicago transit drivers who have accidents, or who appear to be acting in an irrational fashion, perhaps caused by drug or alcohol abuse, will be subject to urine and blood tests.

The question of the right to search has been raised from some quarters, and an employer has a right for an employee to be fit to perform his task, whether this is a job in an assembly plant, on a production line, or, for that matter, in professional sports. The employee has no civil right to violate the law. Apart from that, the employee has no civil right to jeopardize or compromise the safety, not only of himself, but of others, plant equipment, much less the company's reputation or the quality of the product. The company can, it has been determined, require medical examinations for questionable behavior and cause. If the employer is unable to determine what caused this behavior through lack of cooperation by the employee, the employee himself puts his job in jeopardy.

In terms of technology, the urine test mechanisms which are now being used include a test mechanism kit entitled EMIT, which utilizes animal serum that reacts in fact to drugs and alcohol, and which is timely and generally gives gross indicators of a positive or negative presence of THC, heroin, amphetamine, barbiturates, tranquillizers. The exception as of now on the EMIT testing is cocaine. The test has been utilized by the U. S. Navy and by manufacturers and the transportation industry. Their layer chromatography and mass spectometry are more finite definitive tests which can in fact focus on the purity, dosage, chemical levels within a urine sample, and generally are used to verify positive field EMIT tests.

Research by a New Jersey physician using electrocardiograph technique to test chemicals on surface skin is of particular interest. Dr. Westerman, with whom I have talked, indicates this technique has ready application for use by industry or other organizations and associations testing for drugs and alcohol in the human body.

But any program, if stressed from a punitive standpoint only, it seems to me, will miss the point, and that is: the objective is to have a work force that is free from the effects and the use of drugs, both on and off the job. Credible, well-communicated drug policy, employee assistance programs, counseling, health and safety education, as well as good law enforcement liaison and consistent enforcement of company policy are essential.

Some companies may prefer to avoid dealing with the drug abuse issue altogether, and they may stumble through this minefield without harm. But the odds are against that happening. The company that addresses the drug abuse issue is facing reality, for one thing. For another, it is protecting the health of its employees, the quality of its products, and safety of its plant equipment, the integrity of its corporate reputation, and reducing at the same time the increasingly significant costs of absenteeism, high accident rates, theft, increased insurance costs, legal fees, and morale problems, not to mention the highly visible investigative interests by law enforcement and the media. Dealing with the drug abuse problem involves risks, employee resentment, possible misinterpretation by outside parties, and other tangible and intangible costs. But it seems to me that this risk is far outweighed by the benefits of facing up to the issue and dealing from a position of consistency with the complex threat that strikes at the effectiveness of the work force and the company's products and services.

One increasingly significant factor in this equation is the continued reduction of resources available in both the prevention and law enforcement fields to deal with the drug issue itself. Here I am talking about reduced grants in the prevention field as well as reduced funding in the form of drug enforcement dollars for state and local task forces, small offices, and prevention information. Thus private industry, community organizations, will not have the ready availability of federal or state and local training teams, prevention programs, grants in aid, and publications, to assist them on a continued basis in dealing with this problem. At a time when the economy is at a low ebb, unemployment high, corporate budgets tight, and employee-assistance staff under constant review (and in some cases reduced), the ability to deal with drug availability within a plant, or even in a corporate-wide, system, is a very significant task indeed. Company reports are reviewed in terms of assets, profit and loss, liabilities, net worth, but the key asset does not appear on the balance sheet, and that is people. Motivating this resource is one of industry's biggest challenges. Making sure that resource is not compromised by drug abuse is another. And the ability of American industry to stay competitive in costs, product quality, and integrity, will depend to a great extent on how well this challenge is met.

Senator HUMPHREY. Thank you, Mr. Bensinger.

Mr. Small?

Mr. SMALL. Senator Quayle, Senator Humphrey, I am delighted to be here. I want to tell a little bit about the Association of Labor-Management Administrators and Consultants on Alcoholism, ALMACA, because I think next to the development of Alcoholics Anonymous some 46 years ago, the thing that has been growing the most dramatically has been our association in the EAP field.

We started out some 11 years ago in Los Angeles as an organization that represented about 14 occupational alcoholism program managers, and in 11 years we have had a dramatic growth until we have reached the point where we represent the employee assistance field as a professional association for people doing this work in all sorts of worksites and all sorts of locations.

We have 3,200 members in some 50 chapters across the United States now. Much has been said here today, I am happy to say, about just what it is an employee assistance program does. I have been traveling for the last year and a half throughout this ALMACA network in the United States. I have been to most of our chapters, and one of the things that has become very clear to me is that we can sit here in Washington or I can sit in New York in my office at the New York Times and we can think we know what is going on in the 50 States, and really not.

ALMACA chapters are very different all across the country, and I have come to the conclusion that there are enormous amounts of people going around talking about employee assistance programs who are not aware of the simple industrial techniques that are required to administer an effective employee assistance program.

Not every effort to help people in the workplace is necessarily an employee assistance program, although I must say I have seen many, many instances where they are flying under that flag for some reason.

The employee assistance program concept is very adaptable; it is very flexible. It is the type of thing that I can use with the 4,500 employees of my company. You will be hearing from somebody on my right who will be talking about how it is done in a union setting—a labor-based program with a largely female population.

It is working just fine out in Kansas, which is not famous, I understand, for being a very strong labor State. The employee assistance concept is reaching employees there very, very successfully.

What we are talking about here is something that can be easily and inexpensively installed in the workplace, and something that can get enormous amounts of help to employed people very effectively.

One of the things that ALMACA will be doing in the next 2 years—we have spent the last year and a half since I have been president mending our fences and getting our organization shaped up internally. And we are going to be reaching out and addressing some of the things that you Senators have been asking us this morning.

We are going to be addressing why there are not more employee assistance programs and why there are not more occupational alcoholism programs out there. If what we are saying is true, I suspect sometimes we are guilty of presenting a very confused message to the power people in corporations and unions who we would have install these programs.

As we solidify our data and present a message that is consistent in the different States, we will see by 1990 a program in every workplace in the United States for an employee who has an alcohol problem, and all sorts of other problems, too.

We have got to guide industry and unions in just what we mean when we say they should have personnel and staff presences to administer these employee assistance programs to give this effort a focus in the company.

One of the things that has been discussed here this morning, and it is in my written testimony—and I would not want the opportunity to pass without saying that the absence of staff people providing a focus in the Office of Personnel Management in Washington at this Federal level for alcoholism and employee assistance programs gives us some concern, as the removal of the insurance coverage for treatment in freestanding facilities for alcoholism has given us concern.

In many ways, one of the things the Federal Government could do—and I am of the opinion that they could do this inexpensively—is provide model programs to show the rest of the employers in the private sector and the unions in the country that need to invest their own money in having staff to administer these programs what to do.

The employee assistance people in the Midwest, where the economy is not the best, are reporting to the ALMACA board and to our national office that the EAP's are getting called on now as never before, for reasons that we are all very aware of.

In industry where there are layoffs and there are some economic problems, an employee assistance program is heavily used. At the same time, I think that a strong economy is necessary before unions and before management will sit down and endorse the idea of having an EAP and an occupational program in their setting.

The team effort between management, labor, and the workers and the people who use this program, and the skills from personnel management people, labor relations people, and occupational and medical departments, have all heavily influenced what we are doing in the employee assistance field.

Much of what ALMACA is doing was started by the National Council on Alcoholism many years ago. I have heard talk about research this morning. I think it is enormously important, but yet I cannot help but notice that the things that we know work, and work well, in industry are not being done in the vast majority of workplaces in this country. We have talked about why; there are very subtle reasons why sometimes, and they are things that are not exactly going to come out at Senate subcommittee hearings.

One of them is 90 percent of the people in this room probably agree that the word "alcoholism" is used to define an illness. We think of that as a diagnosis, but anybody who has been working in the employee counseling field or the occupational alcoholism field and does not realize that the vast majority of the people in the United States think of alcoholism as a verdict rather than a diagnosis is just not very sensitive to what is going on around them.

As long as that is a verdict in the United States, we are going to have trouble with occupational alcoholism programs, and only some very brave and visionary companies are going to start them.

I think that with my written testimony, that is about all I would like to say at this time. Thank you very much.

[The prepared statement of Mr. Small follows:]

PREPARED STATEMENT OF EDWARD J. SMALL

My name is Edward J. Small and I am the voluntary national president of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) which is the national professional organization that represents the administrators of occupational alcoholism programs. I am employed by the New York Times as the administrator of their Employee Assistance Program. As true with all well-run employee assistance programs, the program at The Times identifies many alcoholic employees and is known among employees and with management and labor as the alcoholism program.

Occupational alcoholism programing is a concept whose time has arrived. During the last 18 months, I have traveled the country to speak at local chapter meetings, regional conferences and alcoholism seminars. I have been struck by the way that the occupational alcoholism concept is adaptable to differing community and industrial settings. In fact, the adaptibility of this concept to local factors may be an important reason why it is growing during a period when many other national thrusts seem to be floundering. What I mean is occupational alcoholism programs thrive best in an environment which encourages program designs responsive to individual situations instead of an environment that attempts to impose a monolithic national model.

Let me explain my point with a few illustrations. We have 46 chapters and no two are alike. In some chapters, we have a preponderance of social workers, in some a preponderance of personnel practitioners, and in others a preponderance of recovering alcoholics who worked in traditional business careers before their recovery and conversion to E.A.P. administrators.

This variety of career types provides strength to the E.A.P. field. It also raises questions among those who look for a single national criteria to guide in hiring or to regulate the people who work in the field. I have asked two of our more active members, Mr. Jim Wrich of United Airlines and Mr. William Combs of the International Association of Machinists and Aerospace Workers to head a Task Force on Credentialing in the E.A.P. field. I will make a recommendation at our November Board meeting. If it turns out that our membership does want some sort of individual credentialing, we will have to balance this with the real and legitimate concerns of industry about outside regulation.

Some of our chapters have many members from organized labor while others have little or no labor representation. This is a factor of the relative strength of labor in different parts of the country. ALMACA has always welcomed labor into our organization and a number of our national board come from labor. We believe that, when a work site is organized, the E.A.P. programs should be jointly supported by labor and management. The point is that the E.A.P. field embraces joint labor-management programs, labor run programs and management run programs. There is not and should not be an attempt to design one model for the whole country.

Employee assistance programs are not only diverse, they are growing. ALMACA membership in the last 18 months has grown from 2,200 to 3,100. The number of chapters has grown from 27 to 46. We do not represent everyone who works in the field. Recent estimates place the number of E.A.P.s in the country at about 5,000. This still represents only a small percentage of the total number of worksites in the country. While its achievement is obviously many years away, a major goal of ALMACA is to extend the availability of employee assistance programs to all workers in the United States.

We believe that employee assistance programs make good business sense. Because of their history and allegiance to the alcoholism field, they are often associated with health care and social service programs. While it is true that the primary objective of E.A.P.s is to develop a healthier workforce, the programs are essentially an industrial administration technique. They seek out and offer assistance to employees who are afflicted by personal problems on the job. The resolution of these problems helps the employee, management, labor, and fellow workers. In all, it provides a valuable tool for American industry.

How can we expand and improve on the E.A.P. concept. First, let me say that a strong economy and a strong E.A.P. go hand-in-hand. Employee assistance programs are heavily utilized in communities and industries which have lay-offs, plant closings, employee transfers and changing technologies. Some of our long-time members, particularly those associated with heavy industry in the mid-west, report increasing case loads as employees and their families struggle to cope with changing employment patterns. However, the ALMACA national board recognized the national need, to strengthen our economy and stop double digit inflation. We feel that industry will increasingly install occupational alcoholism programs but that the rate of growth of these programs is directly related to the strength of our national economy.

The federal government is the largest employer in the country and, as such, serves as a model to public and private employers throughout the country. There have been two recent developments that have caused concern in this respect.

First, was the decision to eliminate Blue Cross coverage for federal employees rehabilitation in in-patient alcoholism centers. While only a small number of persons seen by an occupational alcoholism program require residential rehabilitation, it is essential for the treatment of some. Since this benefit was only provided to employees in 1981, it seemed arbitrary and short-sighted to eliminate a benefit which other employers find so useful without time to gather data about the federal experience.

ALMACA is also concerned that the occupational alcoholism efforts for federal employees will suffer from the recent reorganization of the Office of Personnel Management. The small office that O.P.M. used to have to provide leadership to all federal agencies in developing agency occupational programs has been eliminated. The responsibility is now defuse. ALMACA is willing to work with O.P.M. Director Donald Devine to design ways that this focus can be maintained in a time of lessening federal resources. Our experience in the private sector is that effective occupational alcoholism efforts must have a single focus and have an identifiable office responsible for the program.

Occupational alcoholism programs rely on long standing relationships between and among workers, their supervisors and organized labor. These programs have to be well, integrated with the industrial relations practices in their particular industry. ALMACA and the National Council on Alcoholism have recently adopted program standards for Employee Alcoholism and/or Assistance Programs. This is an early step in establishing a recognition that occupational alcoholism programs are unique and require a disciplined approach. Many ALMACA members are consultants who are in business to provide assistance to industry in designing and installing occupational alcoholism programs. It is important that those of us in the occupational alcoholism field stress two messages to industry. First, that occupational alcoholism programs are a very successful tool for management and labor to achieve healthier workers. Secondly, that occupational alcoholism is a modern, complex industrial concept which should be planned, installed and operated by professionals who are able to manage a concept which utilizes techniques from the fields of alcoholism treatment, personnel management, industrial medicines, labor relations, benefits management and risk reduction.

Occupational alcoholism is a concept whose time has arrived. It remains the most effective way to intervene with people who are suffering from the disease of alcoholism. I believe that it will be used increasingly and that the federal government can support this concept by being a model employer, working toward an improved economy and supporting the efforts of voluntary groups like ALMACA and N.C.A. who are committed to bringing the occupational message to industry.

Senator HUMPHREY. Well, you have said a great deal. Thank you. Dr. Tramm?

Dr. TRAMM. Yes, thank you. My remarks also will diverge slightly from my written testimony because I want to be sure to cover a few points that I feel have not been covered today and may not be.

Senator QUAYLE. Would you move the microphone closer, please?

Dr. TRAMM. I run an employee assistance program for a major international union, the Amalgamated Clothing Textile Workers Union, which still is one of the largest affiliates in the AFL-CIO. There are about 450,000 members, and we run a program through select sites around the country.

The program has a focus on alcoholism because it has been found, in terms of interviews with employers and union representatives, that this was their concern. Also, I think something that should be brought out in these hearings, although I do not have any ready answers, is that it is important pragmatically, particularly in an EAP or in an occupational setting, to distinguish problems with alcohol from, for instance, problems with heroin and other substance abuse, because anybody who is running a business and anybody in industry has a very different attitude about alcohol, which is a legal, sanctioned drug, and heroin, which is an illegal, very high-stigma drug that is associated with crime, minorities, perverts, et cetera.

I guess what I am saying is that there is a need for a sensitivity to the distinctions that people will have, and a need for tremendous education on this issue.

One of the facets that we pride ourselves on in the particular program at the union is trying to get as many women into treatment as possible. Our rate has been as high as a third of our caseload, and I would be willing to answer questions in that regard.

The costs of alcoholism to industry are always asked, and my feeling is that they are a little bit of a red herring. Clearly, the costs are astronomical, but they are very difficult to estimate. The Alcohol, Drug Abuse and Mental Health Administration, ADAMHA, recently came out with national losses in lost productivity and lost employment at $25 billion yearly.

The issue, I think, is to realize that there is a tremendous unmet need, and to try to address it. When we talk particularly about women, one of the problems is that the stigma of alcoholism is horrendous societally because of the fact that we distance ourselves from alcoholics. Everybody in this room knows at least one alcoholic, whether or not we all realize it. But the social stigma of the alcoholic makes us think that these are people who live on skid row. In fact, they represent a very low proportion of alcoholics, generally.

The stigma for women is far, far greater, which makes it difficult for women to enter into treatment, and this is something that must be addressed.

At the work place, the following effects can be attributed to alcoholism, whether among women or men: work not completely or carelessly completed; missed deadlines; excessive absenteeism, including on-the-job absenteeism—going out for frequent breaks, missing from the worksite; excessive medical leave for treatment of disorders which are, in fact, caused by alcoholism but may not be recognized as such—any number, whether they are related to circulatory problems, nervous disorders, intestinal. There are just a host of medical problems that could be and often are created by excessive use of alcohol—quarreling and erratic behavior.

As if these were not enough, these problems introduce an additional problem at the work place, which is low morale and poor attitude among coworkers.

Because of the problems that are produced at the work place, there is a tremendous need for education. The goals of this education—and there are numerous types and I will specify them a little bit—but the goals would be referrals of people with a problem into the program where the program exists; improved statements or more relevant statements in collective bargaining agreements or in personnel procedures, manuals—anything that has been written by either the employer or the union, where the union exists; and also relevant insurance.

Speaking specifically of this education, it is sometimes I feel erroneously called training. You want to educate the people at the work place who are in a position to refer, such as supervisors or union stewards—educate them not necessarily confining yourself to alcoholism and the disease, which may not interest them that much, but about things that are relevant and should be relevant to them—proper supervisory procedures, increased productivity—issues which they feel are relevant.

Another goal of this education would be to streamline the collective bargaining agreements or the collective bargaining language, where it exists. For instance, it is inappropriate to say that somebody who is intoxicated on the job should immediately be fired, or that in the cases of suspected alcoholism, which is not the responsibility of the supervisor to diagnose to begin with, a person should be terminated.

Streamlining the collective bargaining agreement, where it exists, has also been found to lead to increased productivity because there is a proper and a correct channel for people who may be having problems with this drug to go into.

Another goal of education would lead to more appropriate and more specific insurance. Insurance carriers that deal with employed persons should mention and specify alcoholism and perhaps even describe a little bit its treatment. The reason for this is because of the stigma. Most people will assume that alcoholism is not a disease and is not treatable and has nothing to do with a medical issue. If you have something written down which a supervisor in Oshkosh, Wis., or a union steward can read somewhere around the country, this will lead him or her to realize, "Well, this person is covered and alcoholism is a disease," and that will increase referrals for proper treatment.

Turning to the issue of success rate, again I feel that people are talking a little bit on shaky grounds when they talk about success rates. Certainly, when we speak of the ethnic minority population, which is the population that we deal with, the prevalence is not known. So, yes, you are succeeding, but what is the baseline against which you are talking?

However, to give you a few rough statistics, based on a portion of our population which we served in one year—those in the late stages of the disease who had incurred previous hospitalization under other diagnoses prior to referral to the program—each had incurred at least $1,250 in medical and disability benefits during the prior year.

For 112 of those persons who were referred and who were properly treated for alcoholism—if you were to compute this, this would represent a savings of $140,000 to the insurance carrier.

In conclusion, I just would like to stress the theme that the large problem of alcoholism and other substance abuse in this country is public perception of relevance. It is not relevant or correct to consider an alcoholic or another substance abuser a criminal. It is not relevant or correct to be treating alcoholism as pancreatitis or a nervous disorder.

I think the main thing that I would like to stress in closing to combat the problem of lack of perception in this country is education. We need a tremendous amount of education about the disease, starting from the public schools, going into the medical schools, which still are abysmal with respect to hours given to the disease in comparison to its seriousness.

We need education through the media to reduce the mystique of alcoholism. Many of us have just to watch prime time television for an hour to see how sexy and stimulating and brilliant you get when you have a couple of drinks of wine or beer.

We have to reduce the mystique of drinking and recognize that alcohol, like heroin, like valium, is a drug. In terms of a few other remedies or steps that could be taken, I feel that there should be an effort, whether it is started or sanctioned by the Federal Government, to encourage relevant and correct and not costly insurance coverage for alcoholism as a disease.

I would hope that there could be a continued Federal and State strength seen and pushed in this area. Thank you very much.

[The prepared statement of Dr. Tramm follows:]

PREPARED STATEMENT OF MADELEINE TRAMM

My name is Madeleine Tramm. I am the Director of the Health Assistance Program, of the Amalgamated Clothing and Textile Workers Union (ACTWU).

The ACTWU is one of the largest unions in the country, representing an estimated 450,000 members nationally. The industry represents the fields of male apparel, textiles, and shoe production. ACTWU members are predominantly ethnic minority women.

The Health Assistance Program is an occupational program of identification and motivation for treatment of employees and their families whose health problems have begun to interfere with their lives on and off the job. Like many employee assistance programs (e.a.p.'s), the Program has a focus on alcoholism because it has been found that the disease is a major problem in industry, ranking with heart disease and cancer as one of the leading health problems in the United States today.

The costs of alcoholism to industry are difficult to estimate, but clearly astronomical. The federal Alcohol, Drug Abuse and Mental Health Administration estimates national losses in lost productivity and lost employment at $25 billion yearly. The issue, however, from our perspective is not to attempt a calculation, but rather to address what clearly is an unmet need.

The availability of treatment for alcoholism in men does not match the disease's prevalence, because the stigma surrounding alcoholism prevents us from realizing that the disease is all around us. For women, the stigma is far worse. Women alcoholics are destined to suffer on two counts --from the disease itself, and from social stereotypes about women alcoholics.

At the workplace, the following effects can be attributed to alcoholism, among both men and women: work not completed or carelessly completed; missed deadlines; excessive absenteeism, including on-the-job absenteeism; excessive medical leaves of absence for treatment of disorders caused by alcoholism; quarreling; and erratic behavior. As if these were not enough, they can produce an additional problem at the workplace --low morale and poor attitude among co-workers.

The Health Assistance Program is effective because, insofar as employees suffering the effects of alcoholism are reached and referred for appropriate treatment, this employee assistance program curbs the economic and human devastation caused by alcoholism.

Success rate measured as numbers reached as a function of prevalence cannot, in good faith, be stated, because research on the prevalence of alcoholism among ethnic minorities and women is lacking. It is not known how many suffer from the disease. Based on a portion of our population served in one year, however --those in the late stages of the disease, who had required hospitalization under other diagnoses prior to referral to the Program-- each had incurred at least $1,250 in medical and disability benefits. For 112 of these referrals properly treated for alcoholism, this represented a savings of $140,000 to the insurance carrier.

There are more general indicators of Program success. Acclaim by employers and union officials alike, our caseload, the rate of new entrants into the Program, and visibility within the International Union attest to a Program responding to the needs of industry.

Thank you.

Madeleine Tramm, Ph.D.
July 7, 1982

Senator HUMPHREY. Thank you, Dr. Tramm. Dr. Rial?

Dr. RIAL. Mr. Chairman, Cochairman Quayle, I am William Young Rial, a family physician in Swarthmore, Pa., and president of the American Medical Association. With me today is Dr. LeClair Bissell, an internist from New York City, who is a member of our AMA panel on physician mortality and the AMA panel on alcoholism.

I recently gave a speech at which, after the speech was over, one of the guests came up and said, "Dr. Rial, that was the worst speech I ever heard." Obviously, he had had too much to drink, and my host was very embarrassed and said, "Dr. Rial, do not pay any attention to him; he just repeats what he hears everyone else say." [Laughter.]

Well, I will trv not to repeat what everyone else has said, and address myself cnly to the issue of the medical profession and the problem of alcoholism.

The AMA is pleased to be at this hearing to discuss the important issue of alcohol and drug abuse in American industry and professions, and the efforts to deal with this problem through early case-finding and treatment programs.

In response to the Committees' request, I will focus my remarks on the efforts made by the profession to assist physicians who suffer from impairments due to alcohol and drug abuse.

With regard to physician impairment, there is a dual concern. First is the concern the patients of the impaired physician to protect them by identifying those physicians quickly and assisting them in entering voluntary treatment programs or, if necessary, instituting appropriate disciplinary measures such as restrictions on practice or practice under the supervision of a colleague, license suspension or revocation, if appropriate.

The second concern relates to the impaired physician as an individual. The physician, as well as society as a whole, has made a substantial investment in many years of specialized education and training. Impaired physicians unable to optimally function vitiate this investment in training and are unable to adequately serve their patients' needs. Freeing impaired physicians from the misery of alcoholism or drug addiction and restoration of impaired physicians to practice through appropriate treatment and education is a fundamental objective of programs to assist these individuals.

It is always difficult for any person to admit that he or she has a drinking or drug problem. It is particularly difficult when such a person is a physician who has been trained to treat illness and whose career could be severely threatened by the disclosure of alcohol or drug problems.

Notwithstanding this built-in resistance to disclose such difficulties, I am proud to point out that the medical profession was one of the first professions to confront the fact that some of its members suffered impairments, and was the first to take action to deal with the problem.

The AMA has been very active in stimulating programs to assist impaired physicians and to encourage appropriate disciplinary actions against impaired physicians for the purpose of protecting the public. Since 1975, the association has sponsored four national conferences on impaired physicians, with a fifth scheduled this September in Portland, Oreg. At these conferences, sponsors of impaired physician programs from around the country can gather together to exchange information and experiences and to learn of recent developments in the field.

The AMA has also proposed model State legislation that reflects the dual concern for the patient and the physician by amending State medical society practice acts to provide flexibility to the states when dealing with impaired physicians. Where adopted, this flexibility has permitted the State to individualize its response to a particular impaired physician, and permits the State to deal with the problem prior to harm being done to a patient.

The AMA model legislation provides for the restriction, suspension, or revocation of a physician's license because of inability to practice with reasonable skill and safety due to physical or mental illness or disability, including deterioration through the aging process, loss of motor skills, and abuse of drugs, including alcohol.

An important provision of this model legislation and similar State laws is a provision granting the State board of medical practice authority to require such impaired physicians to submit to a mental or physical medical examination.

The AMA also publishes a quarterly Impaired Physician Newsletter with a circulation of more than 3,000 readers to provide information on this issue to any interested part.

The AMA's resident physician section has prepared a booklet entitled "Beyond Survival" that outlines ways in which potential physician impairment problems can possibly be prevented before they materialize. The book focuses on promoting healthful lifestyles during medical school and residency, with particular attention to the formation of mutual support groups.

Mr. Califano's comments to the contrary notwithstanding, the medical schools do indeed make efforts to teach medical students about the problems of alcoholism. I have a tape that the American Academy of Family Physicians makes available to its members which I will provide to the committee to use. It has various vignettes of problems in practice that such physicians may encounter as soon as they start, and then the tape is stopped and the individuals viewing the tape are given an opportunity to discuss how these problems can be handled and how those individuals that are represented by the vignettes in the tape can be assisted to meet the challenge that these stress problems of family practice and general practice and medical practice involve.

Activities at the State level relating to impaired physicians include the following: Disciplinary laws have been enacted by States recognizing disability caused by alcohol and drug use or mental illness. Under these laws, regulatory boards review cases of impaired physicians and recommend license suspension, revocation, or other appropriate disciplinary action.

Hand in hand with this regulatory approach to the problem has been a voluntary approach generally guided by the State's medical society. Today, with the active encouragement of the American Medical Association, societies in all States have established programs to assist impaired physicians. These programs are largely voluntary in nature and represent an effort to assure early identification and treatment for such impaired physicians.

While details differ among the States, most programs involve these elements: One, identification of the impaired physician, such as through observation of a disruption in office practice and other professional duties, or adverse effects of the impairment on interpersonal relationships; two, confrontation of the physician by his peers, usually done through a team approach; three, referral of impaired physicians to an appropriate treatment program or an individual therapist; and four, post-treatment monitoring of the physicians as they prepare to resume their professional lives to be on the lookout for a possible relapse. Often, these activities are carried out in cooperation with the State regulatory agency.

While it is difficult to paint a picture of a State program that adequately describes all the 50 different programs, one statistic is more or less uniform. There is a high recovery rate, as others have testified this morning, by physicians who undergo treatment as a part of this program.

Physicians have proven themselves to be highly motivated once they enter into an alcohol or a drug abuse treatment program. Programs nationwide have recorded a recovery rate in the range, as others have said, from two-thirds to three-fourths of the participants—a level exceeding that in most other alcohol and drug abuse recovery programs and paralleling the better job incentive industry-wide programs.

State medical societies have done an outstanding job in establishing programs to identify and refer for treatment impaired physicians. However, there continue to be problems that represent a challenge for all of us to overcome.

A variety of problems exist with regard to the reentry into professional life of an impaired physician who has recovered. One problem is that a physician who has been out of active practice while undergoing treatment needs to acquaint himself with recent developments in his field of practice.

Second, the physician reentering practice often faces financial difficulties, since most impaired physicians lack adequate financial disability insurance.

Perhaps the most difficult reentry problem is the acceptance by patients and colleagues of the physician who has been impaired and rehabilitated. It is to be hoped that greater education of the public and the profession concerning physician impairment and the true nature of these diseases will help to alleviate this problem.

In conclusion, I would like to applaud the committee for demonstrating its level of interest in the important issue of alcohol and drug abuse in the workplace, and offer the suggestion that our experiences in the medical profession may help to serve as a model for other professions and occupations that seek to deal with their members who suffer impairment due to alcoholism and other forms of drug dependence.

Dr. Bissell and I will be happy to respond to any questions the committee may have. Thank you, Mr. Chairman.

[The prepared statement of Dr. Rial follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Alcoholism and Drug Abuse
and the
Subcommittee on Employment and Productivity
Committee on Labor and Human Resources
United States Senate

Presented by

William Y. Rial, M.D.
and
LeClair Bissell, M.D.

RE: Alcohol, Drug Abuse and Productivity

July 14, 1982

Chairmen and Members of the Committees:

I am William Y. Rial, M.D., a physician in family practice in Swarthmore, Pennsylvania and President of the American Medical Association. With me today is LeClair Bissell, M.D., an internist in New York City. Dr. Bissell is a member of the AMA Panel on Physician Mortality and the AMA Panel on Alcoholism.

The American Medical Association is pleased to be at this hearing to discuss the important issue of alcohol and drug abuse in American industry and professions and the efforts to deal with this problem through education and treatment programs.

In response to your request I will focus my remarks on the efforts made by the medical profession to assist physicians who suffer from impairments due to alcohol and drug abuse.

Importance and Scope of Problem

Alcohol and drug abuses are problems affecting all segments of our society. It is of continuing concern both for reasons of public health as well as reasons related to decreased safety and productivity in the workplace.

With regard to physician impairment, there is a dual concern: first, a concern for the patients of the impaired physician--to protect them by identifying impaired physicians quickly and assisting them in entering voluntary treatment programs or, if necessary, instituting appropriate disciplinary procedures, such as restrictions on surgery, practice under supervision of a colleague, or license suspension or revocation. The second concern relates to the impaired physician as an individual. The physician, as well as society as a whole, has made a substantial investment in many years of specialized education and training. Impaired physicians unable to optimally function negate this investment in training and are unable to adequately serve patient needs. The restoration of impaired physicians to practice through appropriate treatment and education is a fundamental objective of programs to assist impaired physicians.

Physicians appear to be neither more nor less susceptible than other Americans to alcohol-related problems. It would appear that physicians have the same rate of alcoholism as found in the general population.

With regard to drug dependency, the greater accessibility of drugs to physicians may cause physicians to be somewhat more susceptible to this problem. Of the two, alcoholism most likely represents the greater problem in terms of number of physicians affected.

Role of the American Medical Association

It is always difficult for a person to admit that he or she has a drinking or drug problem. It is particularly difficult when such a person is a physician who has been trained to treat illness and whose career could be severely threatened by disclosure of alcohol or drug problems. Notwithstanding this built-in resistance to disclose such difficulties, I am proud to point out that the medical profession was one of the first professions to confront the fact that some of its members suffered impairments and was the first to take action to deal with the problem.

The AMA has been very active in stimulating programs to assist impaired physicians, and to encourage appropriate disciplinary actions against impaired physicians to protect the public. Since 1975, the AMA has sponsored four National Conferences on the Impaired Physician, with a fifth scheduled for this September in Portland, Oregon. At these conferences sponsors of impaired physician programs from around the country can gather together to exchange information and experiences and to learn of the most recent developments in the field.

The AMA has proposed model state legislation that reflects the dual concern for the patient and the physician by amending state medical practice acts to provide flexibility to the states when dealing with impaired physicians. This flexibility permits a state to individualize its response to a particular impaired physician and permits the state to deal with the problem prior to any harm being done to a patient. The AMA model legislation provides for the restriction, suspension or revocation of a physician's license because of inability to practice with reasonable skill and safety due to physical or mental illness or disability, including deterioration through the aging process, loss of motor skill or abuse of drugs, including alcohol. An important provision of this model legislation and of nearly all of the enacted state laws is a provision granting the state board of medical practice authority to require the impaired physician to submit to a mental or physical medical examination.

The AMA publishes a quarterly Impaired Physician Newsletter with a circulation of more than 3,000 readers to provide information on this issue to interested parties.

The AMA's Resident Section has prepared a book entitled Beyond Survival that outlines ways in which potential physician-impairment problems can possibly be prevented before they materialize. The book focuses on promoting healthful lifestyles during medical school and residency, with particular attention to formation of mutual support groups.

Activities at the State Level

The primary focus of activity relating to impaired physicians has been at the state level. Physician disciplinary laws have been enacted by states recognizing disabilities caused by alcohol and drug use or mental illness. Under these laws, regulatory boards review cases of impaired physicians and recommend license suspension, revocation or other appropriate disciplinary action.

Hand-in-hand with this regulatory approach to the problem has been a voluntary approach generally guided by a state's medical society. Today, with the active encouragement of the AMA, societies in all states have established programs to assist impaired physicians. These programs are largely voluntary in nature and represent an effort to assure early identification and treatment for impaired physicians.

In addition to those activities undertaken by state medical societies, many county medical societies have established programs to assist impaired physicians and some hospitals have begun programs to identify impaired physicians on their medical staffs.

In all of these programs, the individuals who have assumed leadership roles in helping their fellow professionals have more often than not been physicians who themselves have been impaired and are rehabilitated.

There is a great deal of variety in the type and operation of state impaired physician programs. This in part is due to varying state disciplinary laws and in part due simply to the employment of different confrontation and treatment approaches. We believe that this diversity of effort is worthwhile as a way of experimenting with different approaches and is preferable to a single uniform model for state programs.

While details differ among the states, most programs involve these elements: (1) identification of the impaired physician, such as through observation of a disruption in office practice and other professional duties, or adverse effects of the impairment on interpersonal relationships; (2) confrontation of the physician by his peers—usually done through a team approach; (3) referral of the impaired physician to an appropriate treatment program or an individual therapist, and (4) post-treatment monitoring of the physician as he prepares to resume his professional life to be on the look-out for possible relapse. Often these activities are carried out in cooperation with state regulatory bodies.

While it might be difficult to paint a picture of a state program that adequately describes the 50 different programs now in operation, one statistic is more or less uniform: a high recovery rate by physicians who undergo treatment as part of the program. Physicians have proven themselves to be highly motivated once they enter into an alcohol or drug abuse treatment program. Programs nationwide have recorded a recovery rate in the range of two-thirds to three-fourths of participants—a level exceeding that in most other alcohol and drug abuse recovery programs.

Future Challenges - Reentry Problems

State medical societies have done an outstanding job in establishing voluntary programs to identify and refer for treatment impaired physicians. However, there continue to be problems that represent a challenge for us to overcome.

A variety of problems exist with regard to the reentry into professional life of an impaired physician who has recovered. One problem is that a physician who has been out of active practice while undergoing treatment needs to acquaint himself with recent developments in his field of medical practice. In this regard, we encourage medical specialty societies (and state medical societies) to design reeducation courses, perhaps on the model of continuing medical education (CME) courses, to assist impaired physicians returning to work. Once a physician has recovered, and has his license to practice reinstated based on a showing that he has recovered, such voluntary reeducation programs help assure high quality care.

Secondly, the physician reentering practice often faces financial difficulties, since most impaired physicians lack adequate disability insurance. Several state medical societies have established grant and loan programs to assist reentering physicians to bridge the financial gap into a financially healthy practice. We encourage more societies to establish such programs.

Finally, there is perhaps the most difficult reentry problem: acceptance by patients and colleagues of the physician who has been impaired and rehabilitated. There is societal prejudice against alcoholics and drug dependent persons that represents a barrier to their resumption of a normal life and career. It is to be hoped that greater education of the public and the medical profession concerning physician impairment and concerning the true nature of these diseases will help to alleviate this problem. Hearings such as this one today are of great value in this regard as they permit public recognition of this important problem and praiseworthy activities by the private sector established to deal with it.

Conclusion

In conclusion I would like to applaud the Subcommittees for demonstrating a high level of interest in the important issue of alcohol and drug abuse in the workplace and offer the suggestion that our experiences in the medical profession may serve as a model for other professions and occupations that seek to deal with their members who suffer impairment due to alcoholism and other forms of drug dependence.

Dr. Bissell and I would be happy to respond to any questions you or the Committee members may have.

Senator HUMPHREY. Thank you, Dr. Rial. Dr. Culpepper?

Dr. CULPEPPER. Thank you, Senator Humphrey, Senator Quayle. I am Burford Culpepper, M.D., assistant medical director of the Du Pont Co. With me today is John F. Dickey of our legal department.

One of my primary responsibilities is overall administration of Du Pont's alcoholism program. I appreciate the opportunity to discuss Du Pont's alcoholism program with the two subcommittees and to share with you the experiences we have acquired over the last 40 years.

Fundamentally, it is our belief that alcoholism is an illness, and one which can be treated effectively. We have operated on that premise since our program began in 1944, 12 years before the American Medical Association recognized alcoholism as a disease.

Our program began as a result of genuine concern for our employees' welfare, and continues for the same reason today. At the same time, Du Pont's commitment to alcoholic rehabilitation stems in part from sound business concerns, based upon our realization that the alcoholic employee can become a useful and productive employee with treatment.

I think the story of how our program first began illustrates the personal involvement that has characterized our work with alcoholics. In 1942, an employee who, unknown to us, was a recovering alcoholic voluntarily intervened in the dismissal of another alcoholic whose work had deteriorated because of his alcoholism. The successful treatment of this employee led Du Pont to institute a nationwide alcoholism program 2 years later.

From such modest beginnings, our program has now been expanded to cover the treatment of our employees, retirees, and their dependents worldwide. The program supplies coverage for nearly 200,000 employees, pensioners, and their families.

Du Pont learned very soon that alcoholism can be controlled by the alcoholic if he or she recognizes the problem and wants to get well. But also noted was another truth. A successful recovery depends heavily on early medical diagnosis and supportive followup programs.

Our response to an employee with a suspected alcohol problem will depend on the seriousness of the problem. For example, a discussion with an employee whose work performance has deteriorated as a result of suspected alcohol abuse might include a caution that he modify his consumption and consider contacting a local Alcoholics Anonymous chapter. Frequently, however, the problem is more severe and a 30-day program in an approved and accredited alcohol treatment center is necessary.

As part of Du Pont's alcohol rehabilitation program, the company pays 80 percent of the cost and the employee continues to receive full wages or salary. The alcoholic employee may resist the idea of going to a treatment center, and it is often necessary for supervision to make it clear that refusal may jeopardize his or her employment.

At the center, the employee receives medical treatment as well as education about the nature of alcoholism and how to meet the day-to-day challenge of sobriety. He or she is removed from some of the pressures of the usual alcohol-related lifestyle and provided a comfortable and supportive environment to begin the process of physical and mental regeneration.

The most critical adjustment period for the alcoholic employee is on returning to home and work. Just as important as a supportive atmosphere at home is the attitude of supervision—one of firm encouragement and understanding. With the help of the site physician, an effective followup program can be provided to the employee. Recovery is aided by support for the employee and his or her family through Alcoholics Anonymous, Al-Anon, Ala-Teen, and other agencies.

Our experience is that approximately 80 percent of those who complete the alcohol rehabilitation program return to productive employment. Although we do not compile companywide statistics, a survey of our physicians in 1964 identified 922 alcoholic employees out of an employee population of about 77,000. It is possible that that number was low because all our alcoholics may not have been known to the plant physician(s).

We believe that our educational program for employees, supervision and management has been successful in enabling us to identify and treat more of our alcoholic employees today. Our education program consists of brochures designed for employees and supervision, a film, and alcoholism seminars at plant sites for management and supervision by our full-time alcoholism counselor.

With your permission, Senator, I would like to make these available for your review. They are the brochures and an occupational medical program that describes also our alcoholism program.

Senator HUMPHREY. Fine, thank you. We would like to see those.

Dr. CULPEPPER. Several articles concerning the health effects experienced by these alcoholics identified by this survey were published, and I have attached copies to my full statement.

[NOTE.—In the interest of economy, the material referred to was retained in the files of the committee.]

Dr. CULPEPPER. The real cost of employing an alcoholic would be very difficult to measure. Although we can estimate the cost of absenteeism, we cannot measure such things as impaired work efficiency, premature death or disability, and the time spent by medical and supervisory personnel in dealing with the alcoholic employee. Thus, we are unable to provide a thorough analysis of the relationships between the cost and the savings that may be generated by the alcoholism program.

Nevertheless, we are convinced that our alcoholism treatment program makes good business sense. In any case, alcoholism is, first and foremost, a human not an economic problem, although one often follows fast on the heels of the other.

We recognize the economic factors involved in administering our alcoholism program, but believe that the program is worth the effort and the cost.

I appreciate the opportunity to discuss our program with you and I would be glad to answer any questions. Thank you, sir.

[The prepared statement of Dr. Culpepper follows:]

STATEMENT OF E. I. DU PONT DE NEMOURS AND COMPANY
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE
SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
JULY 14, 1982

Mr. Chairman, members of the Subcommittees, I am Burford W. Culpepper, M.D., Assistant Medical Director of the Du Pont Company. With me is John F. Dickey of our Legal Department. One of my primary responsibilities is overall direction of Du Pont's alcoholism program.

Du Pont subscribes to the medical opinion that alcoholism is a chronic disease which, if untreated, can result in permanent disability and early death. The disease can be treated if diagnosed early and supported by follow-up programs.

In 1942, Du Pont initiated its formal program under the direction of the Medical Division as it continues at present. Du Pont's was the first program in U.S. industry and is, we believe, the first program to be undertaken internationally. The program is available to nearly 200,000 employees and pensioners and their families. It has evolved into a simple and fair procedure the first steps of which are designed to bring alcoholism into the open so that the employee can be helped. We deal with alcoholism as a medical problem, honestly and positively by giving the affected employee a clear and factual offer to receive help fairly and quickly.

Health Effects of Alcohol Abuse

Chronic alcoholism is a disease of serious magnitude. Our Medical Division studies give some indication of the health problems related to alcohol abuse. In 1964, Du Pont's Medical Division identified, by a survey of company physicians, 922 alcoholics employed by the company out of a workforce of 76,687. This group and matched controls were the subjects of a series of studies to measure the long-term effects of excessive drinking on health and longevity. The findings of these studies demonstrate a strong relationship between alcoholism and chronic disease, cardiovascular disease, sickness absenteeism, and early mortality. These studies have been published and are included as Attachments 1 through 4.

The cohort for all of the studies had the same basis--a survey of company physicians conducted during 1964. We defined a problem drinker as one whose alcohol consumption produced identifiable behavioral changes that led to disturbed personal relations, impairment of work efficiency, or excessive absenteeism.

Three categories were established. One included those who were known to have been problem drinkers in the past, but who at the time of the survey were not drinking; that is, they were thought to be recovering alcoholics. A second group included employees known to be uncontrolled problem drinkers. The third category included employees whose behavior indicated they were problem drinkers, but who could not be definitely classified as uncontrolled alcoholics. For each case, a control was selected who worked at the same installation, was of the same sex, the same payroll classification (i.e., hourly paid or salaried), and was not more than two years older or two years younger than the case.

The first study of prevalence of chronic disease among problem drinkers found after a review of the medical records of the 922 employees and matched controls that:

- the alcoholic prevalence rate as detected by this survey was 12 per 1000;
- the median age was about 50;
- the alcoholic was more likely to have high blood pressure, cirrhosis of the liver, peptic ulcers, asthma, diabetes, mellitus, gout, neuritis, cerebrovascular disease, and heart disease.

The prevalence rate found is undoubtedly below the true rate in the company because all problem drinkers may not have been known to the company physicians. Although these associations may, as discussed in the papers, arise from causes other than alcohol itself, certain of these have been confirmed by clinical, post mortem and animal experimental studies by other researchers.

The second study explored in greater detail the prevalence of cardiovascular disease and the third focused on absenteeism due to sickness among alcoholics. The alcoholic was found to be absent due to illness twice as frequently as the control group and for 1.4 days longer per illness. A difference of 14 days per person per year for uncontrolled alcoholics compared to their controls is an estimate of the average excess of disability days among alcoholics.

The fourth study in this series was a five-year mortality study. The number of deaths in the alcoholic group for the five years of the study was three times the rate of deaths in the nonalcoholic group. Excess mortality was found in all major disease categories considered and greatest for cirrhosis of the liver, cancers of the upper respiratory and digestive tracts, accidents and suicide.

We conclude from these and other published studies that the alcoholic is more susceptible to common degenerative diseases, is absent more frequently and for longer periods and dies sooner than the nonalcoholic.

Treating the Disease

What makes the disease of alcoholism unique is that it is self-induced: the sick person brings on his own sickness. And, the disease cannot be controlled unless the victim himself accepts the reality of the illness even though he or she is often the last to admit that there is a problem. The alcoholic will, in fact, go to great lengths to prove that there is nothing wrong.

Frequent absences, changes in disposition and appearance and reduced job performance often signal the alcoholic's supervisor or the plant physician that help is needed. After medical confirmation that alcohol is the likely cause, a confrontation and offer of assistance is normally necessary.

Du Pont's Alcoholism Procedure

Since the employee is often the last to recognize his or her alcoholism, a special procedure is required to deal with an employee whose job performance is adversely affected by alcohol abuse. This procedure is designed to be flexible in order to accommodate individual needs and thus may vary somewhat at our many plant sites. In all cases, however, our procedure is intended to rehabilitate, not to punish. It is applied as a positive effort to help the employee's rehabilitation.

Once an alcohol problem has been confirmed, a clear understanding is reached between the employee and supervisor regarding what the employee must do to control his alcoholism and continue his employment with the Company. Included in this approach is having the employee accept responsibility and share in the expense of rehabilitation.

The rehabilitation can take one of two courses:

1. In most cases, the employee will remain on the job while actively participating in Alcoholics Anonymous (AA); or,

2. In some cases, the employee will enter a Company-approved alcoholic treatment center for treatment of his drinking problem.

If the employee enters a Company-approved treatment center, the employee is eligible for excused absence with pay on the regular wage or salary roll for a maximum period of 30 calendar days. If the treatment center is Company-approved, 80 percent of the treatment center charge for up to 30 days is normally paid through our health insurance program.

If the employee is removed from the job, frequent contact with supervision and the plant physician is an important part of the rehabilitation.

If job performance does not improve or the employee refuses to enter a Company-approved treatment center, the employee is subject to further action such as a leave of absence without pay for 90 days or termination.

If an employee requests help for a drinking problem before job performance is adversely affected, and supervision and site medical concur there is a problem which justifies coverage under the procedure, site management will offer the same assistance as described above.

Although we do not formally compile company-wide statistics, our experience is that about eighty percent of those who complete the program return to productive employment.

The Alcoholic Treatment Center

To gain our approval, a treatment center must have the basic amenities of a suitable physical plant, a skilled staff of counselors and an intensive 28-30 day program devoted to letting the alcoholic learn to live without alcohol. These are significant factors in how successful such a treatment center will be with its patients.

Each of our approved treatment centers is accredited by the Joint Commission of Accreditation of Hospitals (JCAH) and subscribes to the Alcoholics Anonymous philosophy of follow-up. Prior to approval each center under consideration is inspected and the staff interviewed by a team of three Du Pont people: a representative of a local Du Pont site; an inspector who reviews the adequacy of the building design; and a medical doctor, usually myself, who reviews the adequacy of the medical and rehabilitation programs.

At the center, the employee receives medical treatment as well as education about the nature of alcoholism and how to meet the day-to-day challenge of sobriety. He or she is removed from some of the pressures of the usual alcohol related life style and provided a comfortable and supportive environment to begin the process of physical and mental regeneration.

The Cost of Alcoholism

The cost of alcoholism to industry is made up of several components, including loss of efficiency, absenteeism, faulty decision making, accidents, impaired morale of co-workers, and the cost of rehabilitation programs. A large and significant portion of the economic impact of alcoholism also includes premature disability and death, resulting in loss of many employees in their prime who have skills that are difficult to replace.

A few of these costs have been studied by us and discussed above. The average cost of a 30-day stay in a treatment center is approximately $6,000.

Although we have not done a thorough analysis of the relationship between the costs and the savings that may be generated by the alcoholism program, we recognize that such costs would include the effects of impaired work efficiency, premature death or disability, and the time required by medical and supervisory personnel to deal with the alcoholic employee.

In our view, alcoholism is first and foremost a human, not an economic, problem, although the one often follows fast on the heels of the other. While we realize that the cost of administering our alcoholism rehabilitation program is not insignificant, we believe that the results of the program justify the effort and cost.

DRUG ABUSE

We began periodic surveys of our plant physicians' experience in detection and treatment of drug abuse problems in 1969. Currently, because our surveys have detected only isolated incidences of drug abuse, our sites are dealing with drug abusers on an individual basis. We have under consideration a drug abuse program that would provide more uniform guidance to our sites and we expect that any such program would adopt the principles of our alcoholism program.

Senator **Humphrey**. Thank you, Dr. Culpeppper.

Dr. Bensinger, can you give some advice to people in the field about when urine testing is appropriate, and also other kinds of testing that might be available shortly?

Mr. **Bensinger**. Senator Humphrey, I will share with you my perceptions. I am not a physician nor an expert on pharmacology. My doctorate comes by way of San Marcos University in Lima, Peru, which bestowed an honorary doctor of laws, but I appreciate your confidence.

I think a medical test of new employees which would include a urine test, from the medical experts I have talked to, would be appropriate. There are at least a dozen different characteristics which will appear in a medical test of that nature that would throw off, for example, information on illicit drug use, particularly because many of the illicit drugs do stay in the bloodstream and in the urine sample for a long period of time and have extended half lives.

I also share with I think almost all of the panelists the sense that this effort has got to be first based on the health of the employee. And medical information by law, and I think by good business practice, should be available only to the appropriate medical personnel.

But if a company establishes a policy that individuals that have a problem with illegal drugs will not be employed in sensitive positions, a medical determination and urine test can give that information readily.

In the instance where an individual has seemed to be in a questionable fitness-for-duty category—and here I think Dr. Tramm's comment is appropriate—it may not be that the person is high on cocaine or on marihuana or heroin. It may be that he has not slept for two nights. It may be psychiatric problems; it may be alcohol problems; it may be diabetes. But for one reason or another, that person has some aberrant behavior.

I think a medical examination, including a urine test, can prove valuable and would give the medical authorities and the company itself appropriate information on that. There are different types of tests.

Senator **Humphrey**. Yes.

Mr. **Bensinger**. An E.M.I.T. test is a reactive test in which a very small amount of urine would be analyzed based on some serums that have been developed with animals' reaction. That would give a gross indicator of the inclusion within that individual person of certain substances, including alcohol.

There is generally a need for a higher level confirmation test that could be used, thin-layer chromatography or mass spectrometry, which basically attaches values which I am sure the medical panelists could describe in greater detail. But on aluminum oxide, you can actually find out how far substances move on a thin plate and come up with answers as to just what is in that particular substance.

I do believe that the type of medical review of an individual's particular health and the problems of behavior is not an intrusion. I do not think you can apply it across the board. I do not think you should put it in the hands of nonprofessional personnel. I do not think it can be used as a panacea to solve the drug problem, because it will not.

I think a meaningful prevention health information program will do more than the threat of a urine sample, because many times alcohol and drug abusers will be able to mask and, in fact, account for consumption of illicit or alcoholic beverages and not demonstrate fitness for duty problems.

Senator **Humphrey**. But there are useful tests, and employing them does not necessarily constitute an intrusion?

Mr. **Bensinger**. That would be my belief, sir, and that has been upheld in the Supreme Court and in the Illinois State Supreme Court, where the Chicago Transit Authority determined that after accidents or aberrant behavior, a urine and blood sample would be required of the motormen driving CTA vehicles. This was taken to the Illinois Supreme Court. It was determined in that jurisdiction that the CTA had the right to determine just what caused that aberrant behavior.

Senator **Humphrey**. Mr. Small, how do you go about credentialing counselors? Can a supervisor or someone involved in a business who wants to designate someone get him credentialed through your organization, or what is involved?

Mr. **Small**. You are asking, Senator, a question about something we are still fighting about, and I will have a better answer for you in about 3 years when I am no longer president of ALMACA.

But there are some people in ALMACA who do want some sort of credentialing process, and those people are clinical types who see themselves as certified alcoholism counselors. I have a strong feeling, and so do most of the people in ALMACA as of this year, that the title of the organization accurately reflects the core group that we started out to represent—the Association of Labor-Management Administrators and Consultants on Alcoholism, Inc.

We are not about to credential administrators, managers, labor people, and consultants, because industry knows all about them. They know what they look like, they know what they smell like, they know how to hire them. In many cases, the clinical type person will report to an administrator, and it is the top person or the executive in charge of the program, or the person ALMACA is representing theoretically, that industry does know how to hire.

But credentialing becomes a problem for the people who see themselves as treatment people in the workplace. The vast majority of the people involved in industry are not doing treatment in the workplace. That is being done, and the alcoholism counseling is being done elsewhere, and there are other agencies that are involved in the process of credentialing them.

Senator **Humphrey**. How does someone hire a person?

Mr. **Small**. Right now, they call me and find out for them by talking to them what it is they are looking for. We have got standards for programs. It has taken us over 10 years to agree on a set of standards on just what is an employee assistance program. We finally have that.

Now, our vice president of administration in ALMACA is looking at what people need to have the skills to see that a company is living up to those standards. So, we are really an emerging type of profession.

Senator **Humphrey**. Well, I think it is practical information that if anyone wants to hire such a person, they should call you.

Mr. **Small**. Or they call somebody they know in the State or the area or the region where they are.

Senator **Humphrey**. Well, you know, it sounds silly to us, but to someone who does not know where to begin, that is practical information.

Mr. **Small**. Yes.

Senator **Humphrey**. Dr. Tramm, why is there a greater stigma for women to be diagnosed as alcoholics than for men?

Dr. **Tramm**. There has always been and continues to be a tremendous societal ignorance about alcoholism among women. When I began in the field about 10 years ago, there were consciousness-raising groups around the fact that women could actually be alcoholics.

Perhaps one of the reasons has to do, probably historically perhaps, with AA, which was initially and tremendously successful with men. And then through the fact that many men attended, and consequently many women felt that they could not identify with such a group, women did not enter at such a fast pace. They are entering much more quickly now.

Perhaps another reason has to do with a deficiency in the research, which is also being improved. But I have to say that tremendous strides have been made even in the last 5 years in recognizing the fact that it is a disease that afflicts women as well as men. And I think you could argue, again, kind of blindly about whether half of the alcoholics in the United States are women, or is it really a third? I think it is academic.

The point is that, certainly, they are not being treated at the rate that they exist.

Senator **Humphrey**. Dr. Rial, you disagreed with Dr. Mayer about the preparation of physicians in training.

Dr. **Rial**. With Secretary Califano.

Senator **Humphrey**. OK, Secretary Califano. I would rather have you disagree with a Democrat than a Republican. [Laughter.]

Dr. **Rial**. I would agree wholeheartedly with the comments of Dr. Mayer. I think they were very germane.

Senator **Humphrey**. Well, in any case, what is the situation in training of physicians, and what is your organization doing about it?

Dr. **Rial**. Well, it is very difficult to identify a standard of practice for every 1 of the 120 medical schools in the country, because each school has a curriculum committee that is a law unto itself. Curriculum committees are like Federal laws; once they are on the books and have established a curriculum, it is very difficult to get the chief of a department to change his schedule and have a reduction in the number of hours he teaches, so I cannot guarantee how many hours each medical school devotes to alcoholism

But all of the schools give courses in psychiatry, and part of the course in psychiatry——.

Senator **Humphrey**. Are there any AMA standards for guiding these people?

Dr. **Rial**. The AMA does not have a specific policy with respect to this, but the AMA, as a party to the accreditation of medical schools along with the Association of American Medical Colleges, looks at curricula and does indeed try to respond to it.

Senator **Humphrey**. Are there AMA guidelines?

Dr. **Rial**. Not specifically with respect to alcoholism as far as a teaching subject. Our guidelines deal more directly with the local, State and county medical associations' responsibility with respect to the impaired physician.

Senator **Humphrey**. Well, you know best, I suppose, but it seems like it would be useful to have some models and to have some standards to suggest to these curriculum directors.

Dr. **Rial**. Well, having served on the committee of the National Board of Medical Examiners, which identifies questions that seem to be of enough importance to put them on a national examination for medical students, which is generally the criteria for licensure as well as sometimes for graduation, questions about alcoholism, drug abuse and substance abuse and addiction are all a very important part of that.

So, if they are not getting the course in the medical school, they will certainly know about it when they take the examination.

Senator **Humphrey**. I see.

Dr. **Rial**. I do not know if Dr. Bissell——

Senator **Humphrey**. Dr. Bissell, would you want to respond to that?

Dr. **Bissell**. Well, we have developed model curricula from time to time and have suggested those to the medical schools, but there is no way to force them to adopt them. That is one of the problems.

Senator **Humphrey**. Dr. Culpepper, you have had a program at your firm for a long time which has been highly successful and which has served as a model for others.

Are there options available to employees other than taking a month off and going into a facility?

Dr. **Culpepper**. At the present time, there are no other options. The 30-day referral to an accredited treatment center is our program at the present time.

Senator **Humphrey**. Since you are pioneers, what are you doing in the area of drug abuse, since that is an emerging problem?

Dr. **Culpepper**. Drug abuse has not surfaced as a problem to the exent that alcohol has. The means of detection in our company is determining work performance, and it is usually noted by first-line supervision. We do not see drug abuse as a significant problem in that context, as we do alcoholism. We have a program that will refer employees suspected of drug abuse for treatment, although our drug program is under revision at the present time.

Senator **Humphrey**. Well, you are certainly remarkable in that context. Do you have some screening process to avoid people with those kinds of problems?

Dr. **Culpepper**. No.

Senator **Humphrey**. In hiring, I mean.

Dr. **Culpepper**. Generally, we do not routinely perform substance screening on employees. We would usually allow the individual the right to refuse if, in fact, screening was done or suggested.

Senator **Humphrey**. Thank you. Senator Quayle.

Senator **Quayle**. First of all, I would like to have the record reflect, Mr. Bensinger, my personal feelings toward your service as a past administrator of the Drug Enforcement Agency. I thought you did an outstanding job in your contribution in this area, and it would be remiss of me and others on this committee if we passed without acknowledging it. We certainly appreciate what you have, in fact, done in your life of public service, and we appreciate your coming back today to give us a little bit of insight on the whole issue of alcoholism and drug abuse.

On page 5 of your remarks, at the bottom, you said, "Dealing with the drug abuse problem involves risk of employee resentment, possible misinterpretation by outside parties, and other tangible and intangible costs."

Now, the discussion today has been drug abuse and alcoholism and their effect on productivity. Yet, 90 percent of the discussion has been on alcoholism, and I wonder if you might give us some perspective showing maybe the more difficult problems in identifying drug abuse and some of the remedies that we might pursue beyond your discussion on the urinalysis process.

I believe that this goes to a fundamental problem, and I was struck when Mr. Califano said that what triggered the New York study was heroin, but when he got into it, it was pervasive alcoholism. I am not going to deny his findings because I think they were profound and substantive, but what I am a little bit intrigued about is that now we have gotten away a little bit from the actual drug aspect and we are totally involved in alcoholism.

I am not saying that is not the right way and the proper emphasis, but I would be curious from your perspective if you might give a little balance to the hearing today, since this was drug abuse and alcoholism. As I said, 90 to 95 percent of the testimony has been on alcoholism.

Mr. **Bensinger**. Senator, I think the drug abuse problem in industry is underestimated grossly, and one of the reasons it is is because the individuals really are not comfortable with, familiar with nor can they identify with the users and the symptoms of those users.

The alcoholic has an odor on the breath. Generally, most people in private life have at one time or another consumed too much alcohol and probably physically gone through some of the same symptomatology. Say, this person may be high on alcohol; there is not the same social-criminal implication.

Physically, I think many of the individuals at high school and college did not experience the pot party or, at a social function, passing the cocaine spoons—that level of illegal and drug-related activity.

So, much of the company's attention is focused on things they know and recognize and have gone through personally, point 1.

Point 2, it is more difficult to identify in a number of fashions. I mean, the use and the consumption of marihuana does not set off signals. People who have consumed even large amounts of it may not always get bloodshot eyes, may not always nod and go to sleep, or may not always not be able to drive their car home, although all of those risks, by the way, are clear. I certainly would not want to go home in a motor vehicle driven by someone who had consumed marihuana, simply because that is an increased risk for me. That is one reason.

I think, additionally, the drug abuse issue has been one where some companies do not want to recognize that they have the problem. Why? It involves law enforcement. These are the kinds of costs, tangible and intangible, that I am talking about—misperceptions.

If you have something found in your plant, you call the police. There is a notice in the paper; all of a sudden it gets attention and maybe it is going to scare the public. So, that is downplayed and the stuff is thrown away and no one is notified, and the employee is not helped and the health and safety information is not brought in.

I think that is vital. I think people have a great deal of misconception about illegal drugs and legal drugs, and the combination is devastating. A pill combined with alcohol has a synergistic effect. One and one in this case equals four, and you will have a tremendous deterioration of performance, memory and job effectiveness as a result of mixing both.

So, Senator Quayle, my answer would be that the people at the industrial level, the supervisory level, and the management level I do not think can recognize drug use as easily as alcohol use because they have not gone through it. It is not, societally, as readily identifiable and personal in experience.

Second, I think it tends to not be identified because there are some questionable risks a company will be taking—calling the police, getting involved in making determinations, if somebody is arrested, about what they do. The person has not been proven guilty yet. What is the personnel function? It is a gray area.

Third, I do not think we have called enough attention of employers to the pervasiveness of this problem, and broad enough prevention information to the employees themselves and their families. I think many companies are combining the employee assistance programs and the health and safety information, while recognizing that there are legal distinctions and disciplinary distinctions between the two, and I think you can do it.

I do not think, Senator Quayle, that you need to say you have to separate the employee assistance program. I do not think you need a multibillion-dollar company to have one. I think Ed Small is exactly right; 10 people can have an EAP program, and just call it help and recognition and assistance and referral.

Senator **Quayle**. Mr. Small, do you agree with that?

Mr. **Small**. Do I agree with——

Senator **Quayle**. Do you agree with the basic thrust of what he says, that many companies do not recognize the involvement and that the risks are far greater than in identifying alcoholism, and that there is perhaps a lack of recognition on the pervasiveness of the drug problem?

Mr. **Small**. Well, let me ask you a question, Senator Quayle. You know a lot about this subject now, right? You have been reading up for this hearing. But when I say "drug addict," what do you think of?

Senator **Quayle**. Somebody that is addicted.

Mr. **Small**. To which drug?

Senator **Quayle**. To which drug?

Mr. **Small**. Yes.

Senator **Quayle**. I suppose the first one might be heroin.

Mr. **Small**. OK. Industry is not doing a lot with heroin addicts because a lot of heroin addicts do not work in industry. But we have been working with people who are addicted to all sorts of drugs. If you had somebody from Minnesota here, they would be talking about chemical dependency and being chemical free in the recovery process.

The alcoholism treatment centers have been handling the problems with tranquilizers and marihuana and all sorts of other things, you know, other than illegal street drugs, for a long time.

I do not believe there are a lot of heroin addicts working in industry. You know, it sounds very simplistic, but they cannot afford to work in industry. I know they are there, but not in large numbers. We are not overlooking a lot of them, you know.

I think what has happened over the years is we have called, maybe—I do not know; you would have to ask the doctors this—maybe we have called more "alcoholism" than we should have, you know. But we are seeing a lot of polyaddicted, dual-addicted people. We have been treating them in the EAP's because we do pick them up on job performance, if there is something wrong at work.

Theoretically, it is possible for employees like this to get through the screen if their job performance is not being affected. I will tell you an addiction that gets through the job performance model very easily, and that is compulsive gambling—the addiction without a substance, you know. And yet it is a complete, bona fide addiction. The job performance for the compulsive gambler is often not affected.

We do not do the job there, and I know why. They look OK, physically; they are coming in every day.

Senator **Quayle**. Well, you are the administrator of a program?

Mr. **Small**. Right.

Senator **Quayle**. Do you find it more difficult to detect and have an understanding of when drug addiction, as such, is more of a problem than alcoholism?

Mr. **Small**. No. Alcoholism is the predominant problem. Alcoholism is the all-American addiction. It is legal; everybody makes money on it. It really is, and it will be for years to come.

Another one of the problems we run into, I think—I am not suggesting anybody in this room would do this, but we know that 90 million Americans drink without difficulty. Whatever the number is—it varies depending upon what expert you are listening to—it is the 10 million who have a problem with it as an addiction that need treatment for it that we are here to talk about today.

Alcoholism is a larger problem, and we have been treating people who have—for instance, the alcoholic can often get through the day by smoking marijuana or by taking a couple of tranquilizers. Now, do you want to call that person a drug addict rather than an alcoholic?

As I say, I will defer to other people on that one, but I believe many of us are calling them alcoholics, and that is the way we are treating them in treatment centers.

Senator **Quayle**. In my opening statement I used the statistics that there were 13 million alcoholics in the United States and up to 53 million people using drugs occasionally. Now, you may say that not everybody who uses a drug occasionally is a drug addict, but there certainly would be some effect they would have, particularly in combination with alcoholism.

If that statistic is true, then I think what Mr. Bensinger has said that there is perhaps a lack of recognition, or perhaps an unwillingness to discuss the drug problem—and I am not just talking about heroin because I know there cannot be too many people that are heroin addicts that are going to be productive, whether they are sweeping the floor or are being chairman of the board.

Dr. Culpepper, you have an outstanding program in alcoholism, but what about this comment that has struck me about the lack of awareness and discussion of the drug aspect?

Dr. **Culpepper**. Senator Quayle, I think I would support Mr. Small's observation about the dual abuse problem in some alcoholics. Very often, in my experience as a plant physician and in my experience as assistant medical director, I see alcohol mixed with prescription drugs.

Physicians will treat the alcoholic's related problems which are anxieties and problems that they never attribute to alcohol. Instead, they will attribute these problems to other anxieties, neuroses, et cetera. They will be treated for a long time with rather heavy doses of prescription medication—primarily, the tranquilizer group.

In addition, alcoholism is what usually brings them to detection or into the treatment program in our company. Work performance deteriorates, not because of the drugs they are taking, but because of the alcohol they have taken over a period of time that results in unsatisfactory performance.

In our education program for supervisors, alcoholism is the most common cause of absenteeism. Many of the other things that were mentioned today are also signs of people with alcoholism.

We probably underrecognize drugs in our company and in industry because of two things. One, it does not lead as often to deterioration of work performance as alcohol does; and second, it is illegal.

So, with that connotation, it is difficult to pin down and discuss the drug problem with an employee.

Clearly, in our company we have stated, and will continue to do so, that alcoholism is a disease and it is treatable without the stigma that Dr. Tramm noted.

Senator **QUAYLE**. In your case study when you identify work with a person who is an alcoholic, are most of the cases a mixed problem of alcohol and drugs or is it just strictly alcohol? Is there any delineation between the two?

Dr. **CULPEPPER**. It would be difficult to say if you ever had a pure alcohol problem because, inevitably, the alcoholic has used or has been prescribed some type of tranquilizer medication. The symptoms are those of anxiety and the withdrawal symptoms are those of anxiety, and they are usually treated, without a diagnosis of alcoholism.

Senator **QUAYLE**. Mr. Bensinger, you started this. Do you want to make a final comment?

Mr. **BENSINGER**. I was going to add, Senator Quayle, that I think you have put your finger on one of the problems in perceptions. Heroin is not the only illegal drug that is being talked about. It seems like most individuals are focusing on the addict as related to heroin, and not barbiturates, quaaludes, marijuana heavy consumption, cocaine, amphetamines, and stimulants.

The mixing of drugs and alcohol does not only occur with prescription drugs. It occurs with street drugs, where the individual does not know what he or she is getting, does not know what the dosage or purity level is, and does not know what adultrants are mixed with that drug. And it puts that person, female or male, in the hands of a seller of drugs and violations of the law.

And if that individual thinks that when they go to work, they are free and safe because they used it at home and may never again be picked up at some group party, that is a perception that I think will not prove out because drug dealers will give individuals up in return for information or cooperation.

If there is a use, generally that use is shared with friends, and that friendship is not exclusive when you come to work locations.

So, I do feel that the focus on heroin is unhelpful because it is just the tip of the iceberg of the problem. I do feel also that the availability of street drugs—and they are enormously available—as well as prescription drugs mixed with alcohol many times has been through many of the employee assistance programs without having been documented, in fact, in that fashion.

Dr. **TRAMM**. Senator, I would like to add something also to that. You are touching on issues which are clinically and pharmacologically extremely complex. As testimony to that, I think there are hundreds of new addictive drugs that are probably created and marketed every year.

And I think it is important that people in the employee assistance field recognize this and maintain a bit of modesty about it. I do not think it is appropriate for us to be diagnosticians about whether, in fact, the drug is alcohol or perhaps it is cocaine or heroin. In line with that, I think the most important thing in terms of curbing the cost to industry, which clearly is great and is there, is to educate the people in industry and the people who are in a position to refer on the—to hit them in the veins where it is really going to make the most sense to them—education generally about the prevalence and the seriousness of addicting substances in our society, and educating them about the parameters and the mechanisms for setting up programs of assistance.

You seem to be interested in an issue that is extremely complex, and nobody is denying that there are hundreds and hundreds of drugs that are around and are being created and are being marketed and are being peddled and are being prescribed. It is a very serious problem.

Senator **Quayle**. Well, what I was curious about for the 3½ hours that we have been having these hearings is the predomination of just alcoholism, and that is why I wanted to at least introduce into the hearings, and also get some response on, the drug abuse problem. I think if you have been here throughout the hearings, I think you probably agree that there has been an inordinate amount of conversation on alcoholism.

I tend to agree with you that it is far more complicated. If we want to sit here and try to dissect this out of what it is that we are talking about, we are not going to be able to diagnose that here in this hearing. But I do believe that it is worthwhile to talk about it and I think that it is worthwhile that we focus on it in a balanced fashion rather than perhaps leaving with the idea that our only problem—and I think it is the major problem—would be alcoholism.

The drug use and the drug impact has pervasive and profound effects on productivity, and that is the essence of these hearings.

One final question for Dr. Rial. When Mr. Califano spoke about his meeting up there in Massachusetts with a number of interns, the one intern who spoke got up and said that we ought to focus more on alcoholism, and everybody applauded. I guess there were a couple of hundred there, which would indicate to me—and obviously it did to him; otherwise, he would not have brought it up—that there is within the profession, at least in that particular group at the intern level, a feeling that there has been a lack of adequate attention on the diagnosis of alcoholism.

The statistic that got into that discussion was the fact that 40 percent of the people that go into the emergency rooms are drug or alcohol-related. They keep falling down, and they will go ahead and repair the arm or the rib, but not get into why they fell down, and that goes back to the point that perhaps they have an alcohol problem or a drug problem.

At least he came away with that impression, and if that story reflects an overall industry problem—I was struck by it and I thought maybe you might want to respond further on exactly what you are doing.

I appreciate your comments on the impaired colleagues and impaired professionals. I mean, it takes a lot of courage to get among your peers and say that, and I commend you for it. But I wonder if we might not be missing a little bit of the point as far as what our peers are doing in diagnosing this problem—I am not just talking about cirrhosis of the liver as the result, but I am talking about the actual problem of what brings the patient there.

Dr. **Rial.** Senator, would you mind if I asked Dr. Bissell to respond to this, because I think she is in a better position to indicate the severity of the problem?

Senator **Quayle.** Dr. Bissell?

Dr. **Bissell.** I think we have to sort out three things. Medical schools do an excellent job about teaching the toxic effects of a drug called alcohol on the body. So, we learn all about the liver and what it does to peripheral nerves, and that is peachy.

In the pharmacology course, the average student learns a lot about the actions of the drug as a drug. When you get to dealing with alcoholism—what do you say to one, how do you get over your own embarrassment, how do you deal with that—then the physician is a child of his culture, just like everyone else, and he is not taught.

Of the 120 medical schools, we have about 45 that have some decent teaching on alcoholism. The other two-thirds probably graduated doctors last June who have had 1 or 2 hours on alcoholism, at most. And most of what they have learned, though correct, will be lost as they imitate the behavior of the interns, the residents, and the graduate physicians, who now will do the bulk of their teaching through a role model kind of way.

We need to do a great deal more. Federal money which had been made available under the Hughes Act by the career teacher program has now been pretty much lost. We are doing pretty much only research funding now, so the training efforts are no longer there. It is going to be a long, uphill fight.

The AMA cannot tell a medical school what to teach. We try; we urge.

Senator **Quayle.** I know that they cannot, and they certainly would be in a precarious policy role by trying to dictate curriculum. But I wonder if there might be a way to put more questions on the national boards that would demand the teaching of more alcoholism in schools.

I am not talking about the end result or what caused it. That is an entirely different matter. But if you put a few questions on related to alcoholism, that might be a way to do it.

Dr. **Rial.** I would certainly agree with that, Senator Quayle, and I share Dr. Bissell's comments. My own experience as a practicing physician, though, is when I try to get a patient to stop smoking or when I try to get a patient to stop drinking or to diet or to lose weight, this is the single most frustrating thing that faces me.

I can get them to take drugs; I can get them to go to surgery to even have a heart valve replaced. But I cannot get them to stop smoking, I cannot get them to stop drinking, and I cannot get them to stop overeating. That does not mean that I do not keep trying.

But the statistics show—and this is not anecdotal as Mr. Califano's remark was—the statistics do show that when you ask patients why they have quit smoking or why they have stopped drinking, they say "because my doctor told me to." So, to me, that commands me to continue to do so, but it is still a source of tremendous frustration.

As everyone else has testified, there is denial, denial, denial. "No, doctor; I only have three drinks a day. I have two drinks before supper and then I have a drink at bedtime." Yet, they do not consider themselves alcoholics. But you find out from their families that their work is interfered with, that they are threatened with loss of jobs, and that the kids are mad at them. It is a very difficult situation.

Education, communication and efforts such as these that you are performing now, I think, are very significant and are very important.

Senator **QUAYLE**. Dr. Culpepper?

Dr. **CULPEPPER**. Senator Quayle, let me clarify the record on one point concerning Senator Humphrey's question on routine drug screening. We do routine drug screening in one instance. We have a subsidiary company that makes pharmaceuticals—narcotics—and FDA requires that and all employees associated with that process be screened.

But let me support Dr. Rial's comment about education. I think education is the key to what we should be doing nationwide. I think that it must be the role of the Government to bring alcoholism and drug abuse out in the light as recognized diseases. Then we can appropriately address it. But so long as it is hidden we will never address it properly.

If the Government will play an educational role, industry will help. We are helping with our programs now, and there are many thousands of programs in industry as opposed to a few hundred 10 years ago. I think together we can face this problem and make a big impact on it.

Senator **QUAYLE**. Well, I certainly agree that the problem has not had the proper amount of attention, and that is one of the reasons we are having these hearings. I certainly appreciate all the answers and the candor, and we have a problem of very mutual concern. All of us do share that concern. We may perhaps differ on how we would deal with that concern, but at least it is there.

Reasonable men may differ at times, but as long as we have the same goals and philosophy to achieve those goals, we will all be better off. Thank you all very much.

Senator **HUMPHREY**. Thank you.

Our last panel, if they have not perished from hunger at this point, are Mr. Jerry Knesek of General Motors Corp.; Mr. Lloyd Liscomb, United Auto Workers; Dr. Robert Inskeep, Stroh Brewery; and Dr. Harry Reitan from the Adolph Coors Co.

Thank you, gentlemen, for your patience and for being here today. I wonder if we can ask you to limit your statements to 5 minutes apiece. Your whole statements will be included in the record.

I am going to just turn it over to Senator Quayle at this point.

[Whereupon, Senator Quayle assumed the chair.]

Senator **QUAYLE**. Thank you very much. I would like to first extend a special welcome to a couple of my fellow Hoosiers who are in this panel. When we were in the planning stages of these hearings, we called back to Indiana and asked about successful alcoholism and drug treatment programs. And the response always came back time and time again that the Detroit Allison program was one of the best.

I believe that we will hear some outstanding testimony from Mr. Knesek, who runs the program, representing the management. I believe he has a master's degree in industrial social work from Indiana University, and has been with the program 4 years.

Mr. Liscomb is representing the labor side, and we have got the cooperation of labor and management which is absolutely essential to this program. He is a recovered alcoholic since 1973, and proud of it. After drinking for 26 years, he entered the program as a client and, to the benefit of many others, stayed on and is now in the management of the program. That, to me, is a remarkable story. I am glad that we will be able to hear that.

I also understand that Mr. Liscomb is the father of seven children. So, as the father of three, I must commend you in some way.

But I welcome both of you and look forward to your testimony to this committee. Mr. Knesek, why do you not go ahead and start?

STATEMENT OF JERRY KNESEK, MANAGEMENT REPRESENTATIVE, EMPLOYEE ASSISTANCE PROGRAM, DETROIT DIESEL ALLISON, GENERAL MOTORS CORP., INDIANAPOLIS, IND.; LLOYD LISCOMB, UNION REPRESENTATIVE, EMPLOYEE ASSISTANCE PROGRAM, DETROIT DIESEL ALLISON, GENERAL MOTORS CORP., INDIANAPOLIS, IND.; ROBERT B. INSKEEP, COORDINATOR, SELF-HELP PROGRAM, STROH BREWERY CO.; AND HARRY REITAN, MANAGER, HEALTH SERVICES, ADOLPH COORS CO., ACCOMPANIED BY BEN MASON, CONSULTANT, ADOLPH COORS CO., A PANEL

Mr. **Knesek**. Thank you, Senator Quayle. My name is Jerry Knesek. I am the full-time management representative in the employee assistance program at Detroit Diesel Allison Division's Indianapolis operation. I am pleased to be here today along with Lloyd Liscomb, my United Auto Workers counterpart, who is also involved in our program full-time. Together, we will describe our joint company and union response to employees who are experiencing personal problems, particularly alcohol and drug abuse problems.

Detroit Diesel Allison is a division of the General Motors Corp. We are the largest private employer in the city of Indianapolis, employing approximately 14,000 workers. Of these workers, 4,500 are salaried employees and the other 9,000 are hourly employees represented by the United Auto Workers Local No. 933. Our Indianapolis operations consist of eight plants where we primarily manufacture heavy-duty automatic transmissions, diesel engines and gas turbine engines.

Our management and labor employee assistance program began in the latter part of 1978. Since then, cooperation between local management and the union has gradually become stronger. It is this cooperation that serves as the backbone of our program and we feel makes it effective.

Our major objective is to establish a humane approach to helping employees and their family members who become afflicted with behavioral or medical problems, including alcoholism and/or drug abuse. This is accomplished through a system for the early identification of employee problems, referral for proper treatment, and concerned followup.

We operate our program on the basis of a policy statement agreed to by Detroit Diesel Allison and UAW Local No. 933. It expresses our joint determination to deal cooperatively and constructively with the problems of substance abuse among our employees. It recognizes that alcoholism and drug dependencies are diseases.

Moreover, excessive use of alcohol and/or other drugs by employees impairs their ability to function, contributes to increased absenteeism and tardiness, and leads to violation of shop rules. These, in turn, disrupt work schedules and create dissatisfaction among the majority of our employees who are conscientious about their jobs.

This policy recognizes that these factors have damaging effects on plant efficiency, as well as endangering the job security of our employees. The policy further recognizes that neither management nor the union working alone can motivate the troubled employee to seek treatment. Mutual cooperation is imperative if our program is to work.

To maximize our program's success, we put together a management and union advisory committee. Using input from our committee, we have been able to establish a joint supervisor and union committeeman training program. It focuses on early identification of troubled employees by monitoring deteriorating job performance.

Often in the past, supervisors and committeemen assumed adversary roles over the troubled employee's job performance. As this occurred, the employee became a secondary priority and often progressively deteriorated to the point where his job was in jeopardy.

Through our training programs, and particularly the use of role-playing, we have been able to show supervisors and committeemen that focused, joint confrontation can lead to positive results for management, the union, and most importantly the employee.

We teach the supervisors and committeemen that their role is not to be diagnosticians, but simply to refer an individual to our employee assistance program on the basis of deteriorating job performance. We try to show that a tough love approach of not covering up for the employee yields the greatest chance of recovery.

The second element of our program involves the referral of troubled employees for proper treatment. We do not provide treatment ourselves. Our job in the employee assistance program is to properly assess and diagnose the troubled employee, and refer him or her to a proper treatment facility.

Our treatment resources include inpatient alcoholism treatment facilities, outpatient alcoholism treatment, facilities, and a network of close to 250 self-help groups, including Alcoholics Anonymous and Narcotics Anonymous. Insurance benefits cover the majority of these treatment programs. We use the treatment resources in the Indianapolis community extensively and have found them to be very responsive to the needs of our program.

The final part of our program objective is what we call our concern followup program. In addition to individual followup sessions for those employees who request them, we offer a variety of group followup sessions. Our experience has been that the majority of individuals who participate in our followup program, in addition to the aftercare program established for them by their treatment facility, are able to maintain abstinence.

From July 1978 until May of 1982, we had a total of 1,218 employees who utilized our employee assistance service. This is approximately 7 percent of the total work force. This means our average yearly penetration rate is about 2 percent of the work force. National estimates are that approximately 8 percent of any given work force is experiencing a behavioral/medical problem.

Comparing our average with these estimates leads us to believe that we are not reaching all of our troubled employees in Indianapolis. Much more work needs to be done. We are currently searching for more effective ways of reaching these employees with problems.

Finally, I would like to mention our program's effectiveness. We do not now have any formal means of evaluating our effectiveness other than the impressions Mr. Liscomb and I have and the reputation that our program has throughout our plants. We believe we are successful in helping people return to health and productivity.

However, we are in the process of considering methods to monitor an employee's job performance after program intervention. We believe these will ultimately show that our program is cost-effective.

This concludes my testimony, which has focused primarily on the policies, principles and procedures of our joint employee assistance program in Indianapolis. Our statement for the record of these hearings contains additional information about our local program, as well as some observations on substance abuse from the perspective of our corporate activities. Thank you.

[The prepared statement of General Motors Corp. follows:]

Statement
of
General Motors Corporation
on
Drug Abuse and Alcoholism

Submitted to the
United States Senate
Committee on Labor and Human Resources
Subcommittee on Employment and Productivity
and
Subcommittee on Alcoholism and Drug Abuse

Washington, D.C.
July 14, 1982

General Motors is pleased to submit this statement in connection with the hearings by the Senate Labor and Human Resources Subcommittees on Employment and Productivity and Alcoholism and Drug Abuse on the problems of alcoholism and drug abuse and their effects on productivity in American industry.

The Subcommittees' invitation requested information about the program jointly sponsored in Indianapolis by the United Auto Workers Local 933 and General Motors Detroit Diesel Allison Division to respond to employes experiencing personal problems, particularly those related to alcohol and drug abuse. We are pleased to respond to that request. In addition, we are also providing some information we have learned from our corporate studies about the magnitude of the substance abuse problem.

UAW/GM Local Program: Indianapolis, Indiana

Detroit Diesel Allison (DDAD), a division of the General Motors Corporation, is the largest private employer in the city of Indianapolis employing approximately 14,000 workers. Of these workers, 4,500 are salaried employes and the other 9,500 are hourly employes represented by the United Auto Workers Local 933. Our DDAD Indianapolis operations consist of eight plants where we primarily manufacture heavy-duty automatic transmissions, diesel engines and gas turbine engines.

A DDAD joint labor/management alcoholism recovery program began in 1973 after General Motors and the UAW signed a letter of cooperation agreeing to assist employes in recovering from substance abuse problems. From 1973 through 1978, a core of committed individuals developed the program until a full time Employe Assistance Program (EAP) was set up in July of 1978. (Employe assistance programs are designed for workers with personal problems, including alcoholism and drug abuse.) Since 1978, cooperation between local management and the union has gradually become stronger. It is this cooperation that serves as the backbone of the local program and makes it effective.

The main objective is to establish a humane approach to helping employes and their family members who become afflicted with behavioral or medical problems including alcoholism and/or drug abuse. This is accomplished by the establishment of a system for:

- Early identification of employe problems
- Referral for proper treatment, and
- Concerned follow up

Joint Policy Statement

We operate the program on the basis of a policy statement agreed to by Detroit Diesel Allison and UAW Local 933. It expresses our joint determination to deal cooperatively and constructively with the problems of substance abuse among employes. It recognizes that alcoholism and drug dependencies are diseases and that excessive use of alcohol and/or other drugs by employes impairs their ability to function, contributes to increased absenteeism and tardiness, and leads to violation of shop rules. These, in turn, disrupt work schedules and create dissatisfaction among the majority of our employes who are conscientious about their jobs. This policy statement recognizes that these factors have damaging effects on plant efficiency as well as endangering the job security of our employes. It also recognizes that alcoholism and drug dependency are major causes of family breakdown and violence in the larger community.

The policy statement further recognizes that neither management nor the union working alone can motivate the troubled employe to seek treatment. Mutual cooperation is imperative if the program is to work.

Some of the highlights of our policy statement are as follows:

(1) An employe's behavioral or medical problem only becomes a concern of the company and the union when it interferes with the employe's job performance. To drink or to use drugs outside of the work place is, of course, a matter of choice for an employe. It is only when the effects of alcohol or drug use are brought into the work place that the company and the union have a right to intervene.

(2) Early identification of the employe with a behavioral or medical problem should be based entirely on evidence of poor job performance and other related factors. The immediate supervisor should refer such employes to the Plant Medical Director or his designated representative in the Employe Assistance Program for further evaluation. In this regard, it is not necessary for each supervisor or committeeman to know the symptoms of a behavioral or medical problem. If the employe is represented by the union, a local union representative may be in a position to convince the employe to seek treatment. All supervisors and union committeemen have a responsibility to carry out this policy and to follow procedures assuring that no employe's job security will be jeopardized solely by a request for treatment.

(3) The Plant Medical Director and/or the Employe Assistance Program personnel are available to consult with an employe about the nature of the problem and whether or not treatment is indicated, but we do not provide treatment. After assessing the problem, we refer the employe to an approved treatment center where the employe can

receive the best services available for the problem. In each instance, the EAP records of the employe are kept confidential. They are maintained separately from personnel and other medical records, with access limited to the EAP staff.

(4) The decision to undertake treatment is the responsibility of the employe. The role of the Employe Assistance Program is to assess and advise, with the decision to go or not to go to treatment left up to the individual employe. When a leave of absence is necessary for medical treatment and the employe's seniority or length of service has not already been broken, a medical leave of absence will be granted and the employe will be eligible for benefits in accordance with the standard GM insurance program.

(5) The employe is assured that if the illness is brought under control and job performance becomes satisfactory, his job security will not be jeopardized solely by the decision to seek treatment. However, the employe is also advised to expect no special privileges or exemptions from standard practices. If the employe does not cooperate in obtaining treatment and job performance continues to be unsatisfactory, or if the treatment does not result in a marked improvement in job performance in a reasonable period, management will review the employe's situation and make a determination concerning his future status as an employe, applying appropriate policies and procedures.

(6) We also specify in our joint policy statement that nothing in the policy is to be interpreted as constituting any waiver of management's responsibility to maintain discipline or invoke disciplinary measures in the case of misconduct which may result from or be associated with the use of alcohol or other drugs on company premises.

Joint Advisory Committee

Accomplishing these objectives in the context of the day-to-day operations of DDAD is not easy. To maximize the program's success, we put together a joint management/union advisory committee. It consists of: the president of the union local, the divisional personnel director, the chairman of the bargaining committee, the general superintendent of manufacturing, as well as two other members each from management and the union. Because of this advisory process, we have been able to establish a solid foundation and presence within the context of the larger organization.

Using input from the committee, we have been able to establish a joint supervisor/union committeeman training program focusing on early identification of troubled employes by monitoring deteriorating job performance. This joint training program has been highly successful. We have found that supervisors and union committeemen are eager to help troubled employes, but they are unaware of the proper actions to take. Often in the past, supervisors and committeemen assumed adversary roles over the troubled employe's job performance. As this occurred, the employe became a secondary priority and often progressively deteriorated to the point where his job was in jeopardy. Through our training programs, and particularly the use of role playing, we have been able to show supervisors and committeemen that focused joint confrontation can lead to positive results for management, the union and most importantly, the employe.

The National Council on Alcoholism reported that an employe with an addiction problem typically is on the job for a period of eight to twelve years, with job performance deteriorating to between 50 to 75 percent of efficiency, before intervention takes place. By focusing on these facts and dealing directly with supervisors and union committeemen, we have been able to make tremendous progress towards our goal of early intervention.

We teach the supervisors and committeemen that their role is not to be diagnosticians, but simply to refer an individual to our Employe Assistance Program on the basis of deteriorating job performance. We try to show that a tough-love approach of not covering up for the employe yields the greatest chance of recovery.

We have been pleased with our training process, believe it is critical to our program and feel it is yielding positive results.

Referrals for Treatment

The second element of our program involves the referral of troubled employes for proper treatment. It is important to emphasize that we do not provide treatment ourselves. Our job in the EAP is to properly assess and diagnose the troubled employe for referral to a proper treatment facility.

We work with a wide variety of treatment centers in the greater Indianapolis area. They range from inpatient alcoholism treatment facilities, to outpatient alcoholism treatment facilities, to a network of close to 150 Alcoholics Anonymous and Narcotics Anonymous meetings each week. Insurance benefits cover the majority of these treatment programs. We use the treatment resources in the Indianapolis community extensively and have found them to be very responsive to the needs of our employes. For example, we are currently working with various Indianapolis treatment facilities to develop intensive four-day outpatient alcoholism services in order to provide quality care without having to consider the high cost of inpatient treatment. We hope to have a number of these intensive outpatient programs in operation within the next year.

Follow-Up Sessions

The final part of our program objective is what we call our concerned follow-up program. We have established a follow-up system that has proven to be very effective for those employes who use it. In addition to individual follow-up sessions for those employes who request them, we offer a variety of group follow-up sessions. Every Monday a support group meets at the union hall so individuals can discuss matters of concern to them. On Wednesday evenings, a Narcotics Anonymous meeting is held at the union hall. On Thursday evenings, an Alcoholics Anonymous meeting is held at the union hall and on Friday afternoons another support group is offered. Our experience has been that the majority of those participating in our follow-up program in addition to the after-care program established for them by their treatment facility are able to maintain abstinence from alcohol or drugs. It is very encouraging to observe these individuals on a weekly basis as they redirect their lives in a way that is helpful to themselves and their families as well as to the company and union.

Participation in Program

From July, 1978 until May of 1982, we had a total of 1,218 employees who used the Employe Assistance Program. This is approximately 7 percent of the total work force.

Of those employes:

- 1,039 (85%) were males
- 179 (15%) were females
- 1,048 (86%) were hourly employes
- 170 (14%) were salaried employes

primarily attendance

- 316 (26%) had no work-related problems
- 686 (56%) had alcohol or drug abuse related problems
- 532 (44%) were primarily mental health problems
- 592 (49%) were referred to outpatient treatment facilities
- 392 (32%) were referred to inpatient treatment facilities
- 234 (19%) were referred to organizations such as Alcoholics Anonymous or Narcotics Anonymous

In examining these figures it is important to realize the average annual penetration rate is only about two percent of the work force. Comparing these figures with national estimates that approximately eight percent of any given work force is experiencing a behavioral or medical problem leads us to believe we are not reaching all of our troubled employes.

We are searching for more effective ways of reaching those employes with problems. In this regard, we recently contacted the Indiana University School of Social Work and made arrangements for two master's level students to be assigned for a semester to our Employe Assistance Program. We also have an agreement with the Indiana University School of Nursing that nursing students working on their bachelor's degree are assigned to our Employe Assistance Program. After training and with proper supervision, they will work in the program as employe counselors.

We do not now have a formal means of evaluating our effectiveness other than our impressions and the reputation the local program enjoys throughout our plants. We believe common sense tells us we are successful in helping people return to health and productiveness.

We are considering methods to monitor an employe's job performance after program intervention and believe these will ultimately show the program is cost effective.

With this background of the joint UAW/GM local program in Indianapolis, let us turn briefly to some observations from the corporate level.

Corporate Studies

On a corporate basis, our health services professionals have years of experience in dealing with salaried and union employes experiencing problems with alcohol and drug abuse. However, it has only been in the last few years that we have been able to document the magnitude and seriousness of the problem in the work place, the numbers of individuals impacted and the financial and human costs involved.

Extent of Problem

To those familar with the devastating effects of substance abuse on families and on society in general, it is no surprise that these problems carry over to the work place with equally serious effects on an individual's productivity. Just as alcohol is involved in a large number of accidents on the highways, many industrial accidents also are alcohol or drug related.

As the experience at Detroit Diesel Allison suggests, the joint GM/UAW programs to deal with alcohol and drug-related problems are only reaching a portion of the affected employes. There are many more individuals at GM locations, and in other industries across the country, who remain hidden in the work force while their health and job performance continue to deteriorate.

We believe we have a well-designed employe assistance program at GM which is among the best of such efforts in American industry. However, our most recent studies have heightened our concern about the seriousness of substance abuse problems. We have learned that an increasing number of employes appear to do very well for short periods after becoming involved in our program, but later regress and again experience severe job performance problems.

We first learned of the seriousness of this phenomenon as a result of a series of studies we began in 1979. They reviewed the work history of more than 44,000 hourly employes at four of our divisions. We were able to compare the work records of those employes involved in assistance programs with the records of the remainder of the work force. All of the locations studied had active and respected employe assistance programs. A variety of manufacturing or assembly operations was represented, and the plants were selected to include suburban, inner-city and rural locations.

Study Results

For the first time, we were able to compare large groups of employes based on objective employe records, including such factors as days on the job, sickness and accident benefits paid and excused and unexcused absences. We also were able to evaluate individual work histories. We found that the 4 percent of the work force referred to our Employe Assistance Program during a given year had measurable job performance problems. For some, job performance improved after intervention and participation in EAP and the improvement was sustained. Unfortunately, for a surprisingly large number of individuals the improved job performance was not sustained. This trend is significant and of concern because it did not appear to occur in the early and mid-1960s when some of our local programs were beginning. The reasons for this inability to sustain improved job performance need to be analyzed and understood.

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) over 30 percent of all general hospital admissions are alcohol related. Since alcoholism is a progressive illness, it takes time for it to become a chronic problem resulting in deteriorating job performance. This is consistent with the fact that two-thirds of the employes referred to our assistance program have ten or more years of seniority.

Over the past few years, the importance of early intervention with troubled workers has been emphasized in the joint GM/UAW programs and those in other corporations. However, we are just beginning to learn how to achieve early identification and intervention by using trained personal and historical job performance information. For example, in comparing the work records of those in our EAP program with the remainder of the employes at the locations studied, we identified an additional 17.9 percent of the work force which had performance problems as bad or worse than those referred to our employe assistance programs. Based on our studies, we estimate that approximately 60 percent of these employes had an underlying problem with alcohol or drug abuse.

We found that a relatively constant percentage of employes with poor job performance records do not improve unless intervention occurs and they are forced to confront and deal with their problems. We discovered, for example, over a five-year period about 7 percent of our hourly work force averaged 93 days absence per year for which GM paid sickness and accident benefits. It is important to note this figure does not include the additional work days lost through unexcused absences. Our experience indicates 60 percent of these individuals were likely suffering from alcohol or drug-related problems.

To relate these percentages to costs, we reviewed the records of two employes who were substance abusers. Between 1979 and 1981, benefits paid on behalf of the first individual amounted to $110,000. From 1977 through 1981, the other individual cost $162,929 in benefits paid. Unfortunately, these are neither isolated examples within GM, nor do we believe they are unique to our company.

Because of the toll on the individuals involved and the costs, we are attempting to intervene earlier with those having poor on-the-job records. Unfortunately, many of these individuals are alcoholics or drug abusers and their problems have been allowed to continue for many years. In addition to confronting these patterns of poor job performance, we are developing new approaches and systems to keep performance problems from redeveloping after employes have become involved in our assistance programs and referred for treatment.

Summary

As is indicated by Detroit Diesel Allison's program and GM's corporate studies, the substance abuser brings his problems to the work place. Ninety-five percent or more of all individuals experiencing alcohol or drug-related problems are either employed or the spouse or dependent of someone who is working. It is clear we are facing a problem which transcends the boundaries of the work place. The result in the work place, of course, is increased costs, lower productivity, more accidents on the job, but most importantly additional suffering for the individuals involved.

However, it is important to remember that neither GM nor the UAW can be expected to accept responsibility for those individuals who have the ability to control their own "wellness" and productivity. Any joint union-management substance abuse program can only be catalyst to help individuals confront their problems.

Along with the other groups and institutions concerned with these problems, GM, in cooperation with the UAW and the other unions that represent our employes, is trying to help individuals with alcohol and drug-related problems confront and obtain treatment for their problems. We believe our programs are moving in the right direction.

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Senator **Quayle**. Thank you very much. Mr. Liscomb?

Mr. **Liscomb**. Thank you, Senator Quayle. My name is Lloyd Liscomb and I am a full-time union representative in the Detroit Diesel Allison Indianapolis operations employee assistance program. I am also a member of United Auto Workers 933 in Indianapolis, Ind. I would like to point out that UAW Local No. 933 is currently the largest United Auto Workers local in the State of Indiana.

We currently represent approximately 9,500 workers employed with Detroit Diesel Allison. Local No. 933 was the first UAW local in the State of Indiana to officially start an alcohol recovery program. That program was started in April 1970. At that time, we dealt with alcohol problems only, and our effort was primarily a volunteer one.

At that time, our local recognized that alcohol was a serious problem, leading to job-related problems which might result in termination. We therefore instituted a referral service for employees with alcohol problems on a volunteer basis, and then encouraged them after treatment to attend Alcoholics Anonymous meetings at our union hall.

In September 1973, we expanded our program to include drug abuse as well as alcohol problems. This was primarily done in response to the number of younger employees coming into the work force whose primary drug of choice was something other than alcohol.

In 1978, when Mr. Knesek was hired as management representative of the employee assistance program, we expanded the program to include all problems that could affect job performance, and we officially began a full-fledged employee assistance program. Our referrals come from first-line supervisors, committeemen, the medical department, from family members of the employees, and in some cases from the court system when it pertains to the employee.

I am proud to say that at the present time, we have supportive activities at the union hall for the troubled employees which meet four times a week. On Mondays, we have a support group; on Wednesdays, we have Narcotics Anonymous, and a first in our area—a Nar-Anon meeting; Thursdays, an open Alcoholics Anonymous meeting, Al-Anon and Ala-Teen meetings; and Fridays, we have another support group.

I would like to focus on the importance of having a joint program. Prior to 1978, what we actually had was a union-oriented program. Although I am not trying to underestimate the efforts of the program and its success, because it was successful in what we were doing, I feel that the effectiveness of our program has greatly increased due to the fact that management has joined our efforts and we now have a joint program.

Another important event which I would like to highlight is that in 1978, the program was moved away form the personnel department and put under the medical department. The move to the medical department, I feel, has made the program more effective due to the medical department's emphasis and respect for confidential material.

I feel it is important to give you some idea of our program's effectiveness. For this reason, I have decided to share with you four histories of our employees who have been involved with our employee assistance program and who we feel are currently recovering from not only their alcohol or drug problem, but in terms of job productivity.

The cases to which I will refer were selected at random. However, we believe them to be a reflective analysis of the overall success of the people who are currently in the employee assistance program at Detroit Diesel Allison in Indianapolis. For confidentiality purposes, the names of the individuals I will be using are not their real names.

The first person I would like to talk about is a man we call John. He is 29 years old and has 4 years with Detroit Diesel Allison. He was cross-addicted on alcohol and drugs. He was hospitalized three times, twice for alcohol and once for drug addiction.

Since his last hospitalization, John has been active in his after-care plan. He is working the program 12 months out of the year. He is very much involved in Narcotics Anonymous. Six months prior to John's hospitalization, he had 598 hours' absenteeism. Six months after his hospitalization, we had reduced his absenteeism by 60 percent.

Another one of our cases we will call Joe, who is in his late 30's and has 9 years' seniority. This gentleman was hospitalized four times. He was also referred to a drug treatment facility through the courts at one time. His absenteeism was so bad that the company terminated him. At the time of his termination, Mr. Knesek and myself got involved with him once again in a drug program.

Joe was without a job for approximately 3 months. During this time, he followed his after-care program and attended support groups. We went to the personnel department and recommended that the company rehire him. They did rehire him, and the first 6 months after returning to the job, we reduced his absenteeism by 75 percent, compared with 6 months prior to hospitalization.

The next client we will call Harry. He is 55 years old and has 25 years' seniority. He has grown children and is a grandfather and job-setter by occupation. He had no absentee problem. In fact, Harry was a workaholic. Harry saw that his job performance was deteriorating and he was beginning to have trouble at home because of his use of alcohol. He got to the point where he would not go home.

His wife called me and asked me for assistance. Even though Harry's foreman suspected Harry had an alcohol problem, he did not feel that the department could run without Harry because of his position as a job-setter. Harry knew that his alcoholism was beginning to get completely out of control, so he came to my office and told me he had to do something about his problem.

On checking Harry's work record, we found that he had been working 7 days a week, on an average of 10 hours a day, and he had done this for several months. Harry was admitted to the hospital for treatment, and since his release he is following his after-care plan and going to support groups and A.A. meetings. He has cut his workload down to 40 to 48 hours a week.

Not only did the hospital work with him on his alcoholism, but they also worked with him on his addiction to work. There is no doubt in my mind that if he continues to follow the after-care plan that has been laid down for him that he will have continued sobriety.

Our next client we will call Ron. He is 30 years old, a married machine operator. Ron was the type of person who would not go to any kind of a hospital for his alcoholism. He decided instead that he would do it on his own and he worked with Jerry Knesek and myself. He went to Alcoholics Anonymous, and he did it; Ron has been sober approximately 2 years. He goes to at least three A.A. meetings a week. He also attends our support groups. Ron's absenteeism went from 90 days 6 months prior to joining our program to 11 days 6 months after joining our program. We had a 90-percent reduction in absenteeism in Ron's case over a period of 6 months.

The last case I would like to talk about is that of Jamie. He is 24 years old, single, and a burr and blend man with Detroit Diesel Allison. James was in treatment four times for alcohol and drug abuse. Jamie was terminated for destruction of company property; he happened to be under the influence at the time.

He was referred to a drug treatment program, where he stayed for a period of 30 days. Since being released from the hospital, he is attending support groups and A.A. meetings. Jamie has over 5 months of sobriety at this time, but he is still terminated. At this point in time, he does not have a job. However, from our perspective, this may have been a crisis that turned his life around. From our program's perspective, the bottom line is that he is sober today and has good sobriety.

These reductions in absenteeism represent a substantial cost savings to the company and the union. However, more important, as far as I am concerned, is the progress I have seen these individuals making in their own lives.

This concludes my testimony, and I would like once again to thank this committee, and primarily Senator Quayle's office, for inviting myself and Mr. Knesek to be with you today.

[The prepared statement of Mr. Liscomb follows:]

Testimony for July 14, 1982
Senate Subcommittee Meeting
Washington, D.C.

As Mr. Knesek said, my name is Lloyd Liscomb. I am the full time union representative in the Detroit Diesel Allison Indianapolis operations employee assistance program. I am also a member of the United Auto Workers, Local 933 in Indianapolis, Indiana. I would like to point out that UAW Local 933 is currently the largest United Auto Workers Local in the state of Indiana. We currently represent approximately 9,500 hourly workers employed by Detroit Diesel Allison. Local 933 was the first UAW Local in the state of Indiana to officially start an alcohol recovery program. That program was started in April, 1970. At that time we dealt with alcohol problems only, and our effort was primarily a volunteer one. At that time, our Local recognized that alcohol was a serious problem leading to job-related problems which resulted in discharge. We therefore instituted a referral service for employees with alcohol problems on a volunteer basis, and then encouraged them after treatment to attend Alcoholics Anonymous meetings at our union hall.

In September of 1973, we expanded our program to include drug abuse as well as alcohol problems. This was primarily done in response to the number of younger employees coming into the work force whose primary drug-of-choice was something other than alcohol.

In 1978, when Mr. Knesek was hired as management representative of the Employee Assistance Program, we expanded the program to include all problems that could effect job performance, and we officially began a "full-fledged" Employee Assistance Program. Our referrals come from first-line supervisors, Committeemen, Zone Committeemen, the medical department, from family members of the employee, and in some cases, from the court system when it pertains to the employee.

I am proud to say that, at the present time, we have supportive activities at the hall for the troubled employees, which meet four days a week. On Mondays, we have a support group; Wednesdays, we have Narcotics Anonymous, and a first in our area, a Nara-Non meeting; Thursdays, an open Alcoholics Anonymous meeting, Ala-non and Ala-Teen meetings; and Fridays, we have another support group.

I would like to focus on the importance of having a joint program. Prior to 1978, what we actually had was a union-oriented program. Although I am not trying to underestimate the efforts of the program and its success, because it was successful in what we were doing, I feel that the effectiveness of our program has greatly increased due to the fact that management has joined our efforts, and we now have a joint program. Another important event which I would like to highlight is that in 1978, the program was moved away from the personnel department and put under the medical department. The move to the medical department, I feel, has made the program more effective due to the medical department's emphasis and respect for confidential material.

Like Mr. Knesek pointed out, we do not currently have a formal means of evaluating our program. However, I do feel it is important to give you some idea of our program's effectiveness. For this reason I have decided to share with you three or four histories of our employees who have been involved with our Employee Assistance Program, and who we feel are currently recovering from not only their alcohol or drug problem, but in terms of their job productivity. The cases to which I will refer were selected randomly, however, we believe them to be a reflective analysis of the overall success of the people who are currently participating in the Employee Assistance Program at Detroit Diesel Allison in Indianapolis. Needless to say, for confidentiality purposes, the names of the individuals I will be using are not their real names.

The first person I would like to talk about is a man we call "John". He is 29 years old; has four years with Detroit Diesel Allison. He is white. He was cross-addicted on alcohol and drugs. We had this person hospitalized approximately three times, twice for alcohol and once for drug addiction. Since his last hospitalization, John has been active in the aftercare plan. He is working the program 12 months out of the year. He is very much involved in Narcotics Anonymous. Six months prior to John's hospitalization he had 398 hours absenteeism. Six months after his hospitalization we had reduced his absenteeism by 60%.

Another one of our clients we will call "Joe," who is in his late 30's. This gentleman was hospitalized four times. He was also referred to a drug treatment facility through the courts at one time. His absenteeism was so bad that the company terminated him. At the time of his termination, Mr. Knesek and myself got involved with him once again in a drug program. Joe was without a job for approximately three months. During this time he followed his aftercare program and attended support groups. We went to the personnel department and recommended that the company rehire him. They did rehire him, and the first six months after returning to the job we reduced his absenteeism by 75%, compared with the six months prior to hospitalization.

The next client we will call "Harry." Harry is a white male, 55 years old, married with grown children, a grandfather and job-setter by occupation. He had no absenteeism problem; in fact, Harry was a workaholic. Harry saw that his job performance was deteriorating, and he was beginning to have trouble at home because of his alcohol. He got to the point where he wouldn't go home. His wife called me asking for assistance. Even though Harry's foreman suspected that Harry had alcohol problems, he didn't feel that the department could run without Harry becuase of his position as job-setter. Harry knew that his alcoholism was getting completely out of control with him, so he came to my office and told me he had to do something about his problem. On chekcing Harry's work record, we found that he had been working seven days a week, on an average of ten hours a day. And, he had done this for several months. We put Harry in the hospital and since his release, he is following his aftercare plan, going to support groups and A. A. meetings. He has cut his work load down to 40 to 48 hours a week. Not only did the hospital work with him on his alcoholism, but they also worked with him on his addiction to work. There is no doubt in my mind that if he continues to follow the aftercare plan that has been laid down for him that he will have continued sobriety.

Our next client we will call "Ron." Ron is a white male, 30 years old, with five years with the company. He is married and a machine operator. Ron was the type of person who would not go to any kind of hospital for his alcoholism. He decided instead that he would do it on his own, and he worked with Jerry Knesek and myself. He went into Alcoholics Anonymous, and he did it. Ron has been sober approximately two years. He goes to at least three A.A. meetings a week. He also attends our support groups. Ron's absenteeism went from 90 days, six months prior to joining A.A., to 11 days for the six month period after joining A.A. We had a 90% reduction in absenteeism in Ron's case over a period of six months.

The last case I want to talk about is that of "Jamie." Jamie is a white male, about 24 years old, single, and a burr and blend man with Detroit Diesel Allison. James was in treatment four times for alcohol and drug abuse. Jamie was terminated for destruction of company property while under the influence of drugs. He was automatically terminated when this happened. Mr. Knesek and myself put him in a drug hospital where he stayed for a period of 30 days. Since being released from the hospital, he has followed the recommended aftercare plan by going to the hopital for aftercare. He is also attending support groups and A.A. meetings. Jamie has over five months sobriety at this time, but he is also still terminated. At this point in time he does not have a job, however, from our perspective, this may have been the crisis that turned his life around, and from our program's perspective, the bottom line is that he is sober today and has good sobriety.

Needless to say, these reductions in absenteeism represent substantial cost savings to the company and the union. However, more importantly, as far as I am concerned, is the progress I have seen these individuals make in their own lives.

This concludes my testimony. I would like to once again thank this Committee, and primarily Senator Quayle's office, for inviting myself and Mr. Knesek to be with you here today.

Lloyd Liscomb

Lloyd Liscomb
Chairman, Employee Assistance Program
Local 933, United Auto Workers
2320 S. Tibbs Avenue
Indianapolis, Indiana 46241

Senator **Quayle**. Thank you very much for your valuable testimony, both of you.

Dr. Inskeep?

Dr. **Inskeep**. Mr. Chairman, Senator Quayle, it is a pleasure to be here with you this afternoon to discuss our company's efforts in addressing the problems of drug and alcohol abuse and the serious emotional problems among our employees and their families.

My remarks this afternoon will primarily focus on the theme of commitment, cooperation, and communication as something that we found very important in terms of our efforts to put together a successful program to impact upon substance abuse problems in our company.

I think the best example of cooperation and commitment comes from the beginnings of the program in late 1977, when representatives of the National Council on Alcoholism's Labor and Management Task Force approached our president, Peter Stroh, with the idea and request for a commitment to put together an employee assistance program for his employees.

In the establishment of that program, Mr. Stroh and the officials who represent the unions at Stroh were acting very consistently, I feel, with the longstanding Stroh family commitment to the health and well-being of all of our company's employees and their family members.

Over a period of 10 months, a joint committee of union, management, and NCA representatives worked to produce a program that was unique to Stroh's needs, and the description of that program I think is well portrayed in the booklet that is attached to my testimony.

But even more, time and resources were made available to make the program beginnings a successful venture, as well as later on once the program was underway.

In January of 1979, I joined the Stroh Brewery Co., as the self-help program coordinator, and I began to focus on the primary objective of providing timely mental health services to employees and family members who were experiencing personal problems in order to reduce the degree of death, disability, dollar loss, and human suffering in our work force.

Our model for accomplishing this objective closely followed the traditional EAP models that have been described this morning and this afternoon. We had the full cooperation of unions and management in putting together a program which would impact maximally on the problems that our workers were experiencing.

We immediately began to focus upon the cornerstone of insuring maximum program utilization—that of educating our employees about the helpful nature of the program, while assuring them that no harm would occur to them as a result of their participation in the program. We accomplished this by what seems like an endless barrage of information about the program and speaking to groups of employees and training them about the program and what it could accomplish, at the same time adhering to a strict policy of privacy and anonymity with regard to program participants.

We recognized the need to identify some special needs, also, within our work force very early in the program. We saw that there was a need for wide-scale information and education about substance abuse, about alcohol, and about drugs; a need for identifying community mental health services that were available to our employees at nontraditional times of the day, because we are a shift-work operation, and in nontraditional locations.

We were also interested in identifying flexible programs for reducing stress associated with working 6 and 7-day workweeks. We are beginning to address those special needs by a number of educational programs, one-to-one counseling separate from the self-help program provided by the medical department, and the active cultivation of community resources who are willing to accommodate themselves to the special needs of our employees and the special times at which they don't work and are available for counseling

Something that I am particularly excited about is the establishment of an inplant network of volunteers—individuals who have been helped by the self-help program, and others who have resources available to them—an inplant network of volunteers to work together to explore and assist me in implementing some special assistance programs in the company to augment what we are doing in the self-help program.

I am pleased that both Stroh management and labor have supported our program totally. They have supported the confidential nature of the program; supported the neutrality of the EAP office, the provision of company time for training employees, the modification and computerization of time and attendance procedures in order to aid in motivating employees to come to our program for help, and, in particular, the enhancement of medical benefits to better serve persons with substance abuse problems. Those benefits are described in one of the attachments to my testimony.

Top management and labor have also had a commitment to search for unique opportunities to reach and assist our troubled employees. Some of those unique services have included the establishment of a bereavement and funeral assistance program to people who are experiencing the crisis of a death in their family; a 24-hour, 7-day-a-week EAP hotline; and, beginning this fall, educational seminars to draw family members into the program office.

Management and labor have insisted that the self-help program remain responsive to the needs of our work force by establishing a joint labor-management advisory committee, regularly reviewing our program utilization data, and recently commissioning an extensive program evaluation study which began July 1, under the auspices of a local university.

Now, although the formal program evaluation has just begun, we are beginning to see indications that the program is having a definite positive impact. We are encouraged that in providing professional help to 328 employees and dependents after 3 years of operation, we believe that we have already reached a significant portion of our at-risk population.

It seems a representative portion of our salaried employees, our female employees, and minority employees are receiving help through the self-help program. The 328 participants have manifested a broad variety of problems, and they have been referred to us through a variety of referral sources, which is particularly encouraging.

When the program first began, about 75 percent of the referrals to the program were self-initiated. We are now finding that closer to 50 percent are self-initiated, with families, different departments within the company, and supervisors taking a more active role in making referrals.

A reaction to the comment that Senator Pell made earlier: I am particularly encouraged by the family participation in our program and the increase in the number of families who are referring sons and daughters and husbands and wives for help. This proliferation of "second and third generation referrals" to the program seems to be based on the positive experience that employees or relatives have had with treatment in a program.

Our experience parallels that of other industries, with between 55 and 65 percent of the program participants indicating reductions in absenteeism, grievances, disciplinary actions, and accident rates.

As a researcher, I am looking forward to the completion of the formal program evaluation in the fall to be able to gage the true net effects of the program on worker health and behavior at our company. But we are encouraged by these early signs and we intend to redouble our efforts in the years ahead.

In closing, let me say that I am pleased to be associated with a human service venture which works as well as employee assistance programing. I have worked for 10 to 15 years in the mental health field, and I am encouraged by the degree of cooperation, communication, and sharing that has gone on since I have been involved and associated with employee assistance programing.

I have given some examples of the cooperation and the commitment that have been manifested in our company and in working with the U.S. Brewers Association, the ALMACA organization, and other cooperative projects that we have been involved in.

But I would like to take just a minute to expand on this cooperative notion in light of the questions that were raised earlier, particularly in regards to the role of government in impacting on the recognition and response to the problems of drug and alcohol abuse in our work force.

I believe that the most helpful role that government might play is one of being a catalyst in supporting cooperative efforts at local and regional levels, nationwide. I stress "cooperative" because I believe that the answer to a pervasive, multidimensional problem, such as substance abuse, needs a multifactored, multifaceted response to it. And only through cooperation and communication and sharing of ideas and techniques can we expect to impact on this problem successfully.

I am suggesting that government look for opportunities to bring people together who might have been previously antagonistic in the field of alcohol and alcohol abuse and treatment, and encourage those who are already doing cooperative things to increase their cooperative efforts.

Just a couple of quick examples before I close: I think an excellent example of cooperation was the production of the employee assistance program model manual that the U.S. Brewers Association put together a year or two ago with the cooperation of ALMACA, the National Council on Alcoholism, the AFL–CIO, and the brewers.

Locally in Detroit, we are working very closely with the National Council on Alcoholism. Several of our management people are serving on their board, and we are providing primary support to a program that they have entitled the Babes program, which is a prevention and an education effort aimed at impacting on elementary schoolchildren.

I think one of the best examples of cooperation that is just getting started in the Detroit area is in the research area. In Detroit, a consortium dedicated to the advancement and application of substance abuse research, especially in the work force, has been formed a year ago, and it was named MARC, which stands for the Michigan Alcoholism Research Consortium.

Without getting into the details of the consortium, I believe that what speaks most highly about the initiation of this consortium is the variety in those who have joined forces in order to develop meaningful substance abuse research. They include representatives from GM, Ford, Stroh's, Chrysler, Detroit area hospitals and outpatient clinics, Blue Cross of Michigan, the UAW, the Wayne State University Medical School, the Salvation Army, the National Council on Alcoholism, and the University of Michigan, to name about half of those participating in this consortium.

To close, let me suggest that government could provide a valuable service by getting out into the field and discovering, encouraging and fostering cooperative local efforts in helping to peak people's awareness about the problems of substance abuse in business and industry, and to develop techniques for the treatment of substance abuse in business and industry.

I have a feeling that there are a number of initiatives out there that are well underway, and government's best service could be to help remove some of the obstacles to those projects becoming a success, without initially being overly concerned about creating these unique ventures. I believe that such cooperative ventures are already occurring, and I am encouraged with the number of them I see taking place and having an impact on the problem that we are here to discuss today.

Thank you for this opportunity to share our experiences and our ideas, and I would be happy to answer any questions that you might have. Thank you.

[The prepared statement of Dr. Inskeep follows:]

Testimony Prepared for Presentation by the Stroh Brewery Company

Dr. Robert B. Inskeep

Before the Hearing on the Effects of Alcohol and Drug Abuse
on Productivity

Held Jointly by the United States Senate Subcommittee
on Alcohol and Drug Abuse
and the United States Senate Subcommittee
on Employment and Productivity

July 14, 1982

In late 1977 representatives of the National Council on Alcoholism Labor/Management Task Force asked Peter Stroh, President of Stroh Brewery, for a special commitment--a commitment to establish an employee assistance program at Stroh to provide his employees with the best vehicle for intercepting alcoholism and other personal difficulties before these problems destroyed their jobs and their lives. His commitment was quick in coming and has not wavered over the past five years. It lead to the establishment of the Stroh Self Help Program, and was consistent with a long standing Stroh family commitment to the health and well being of all company employees and their family members through the provision of comprehensive benefits and services.

It is within this tradition that Mr. Stroh invited the Task Force to consult on the design of a quality employee assistance program for Stroh. Over a period of 10 months a joint committeee of union, management, and NCA representatives labored to produce a program unique to Stroh's needs but incorporating all of the principles essential to sound employee assistance programming. The Program Objective, Policy and Acknowledgements cited on the last page of the attached Self Help Program brochure testify to the success of their sustained and conscientious efforts.

In January of 1979 I joined the Stroh Brewery Company as the Self Help Program coordinator and began establishing procedures for meeting employee needs, promoting program services and training supervisory and union staff in making the most effective use of the program. From its inception the primary objective of the program has been the provision of timely mental health services to employees and family members in personal strife in order to reduce the degree of death, disability, dollar loss, and human suffering within our workforce. Under the traditional EAP model this is accomplished by placing a mental health professional in the work setting to assess the nature of employee problems, explore treatment alternatives with the individuals, refer them to community agencies when necessary, and provide follow up support to these employees. To accomplish this end a great deal of program structuring and preparation of the workplace is necessary to encourage employees and their dependents to utilize the service on a self-referral basis before a serious problem develops in their home or work setting, and to encourage supervisors, union representatives and medical department personnel to utilize deteriorating work performance and health as leverage for affecting a referral for EAP services.

A cornerstone of insuring maximum program utilization rests in the dual task of educating employees about the helpful nature of the program while simultaneously assuring them that no harm will occur as a result of their participation. We have accomplished the former through a continuous barrage of company and union newsletter articles, posters, testimonials of successfully treated employees, annual employee training sessions and letters to employees' homes such as those attached to this report. A strict adherence to the privacy and anonymity of program participants has helped dispell fears that referral will adversely affect one's work status.

From the outset it was clear that our workforce had special needs for receiving wide-scale information and education about substance abuse, identifying community mental health services available at non-traditional hours and locations, and participating in effective, flexible programs for reducing stress associated with six and seven day work weeks. We are beginning to address these needs at Stroh by means of one to one counseling by the Medical Department, the active cultivation of community resources willing to accommodate the special scheduling needs of our people, and the establishment of an in-plant network of volunteers to explore and assist in the implementation of special assistance programming.

Structuring of the program and establishing its credibility has been greatly enhanced by Stroh management and labor. The support of both has been total with respect to the confidential nature of the program, the neutrality of the EAP office, the provision of company time for training employees, the modification and computerization of time and attendance procedures to aid in motivating troubled employees to seek help, and the enhancement of medical benefits to better serve persons with substance abuse problems.

Top management has encouraged innovative steps to reach employees at times of crisis by supporting the establishment of bereavement and funeral assistance, a 24 hour, seven day a week EAP hot line and educational seminars to draw family members into the program office. They have insisted that the Self Help

Program remain responsive to the needs of our workforce by establishing a joint labor/management advisory committee, regularly reviewing program utilization data, and commissioning an extensive program evaluation study under the auspices of a local university.

All of us committed to the EAP concept are pleased to see the Stroh program firmly established and producing positive results. Although formal program evaluation has just begun, preliminary information indicates that the program is having a definite positive impact. Based on estimates that between 15 and 25 percent of the American workforce will experience a need for professional mental health services in the course of their lives, we have concluded that 1,600 of our approximate 6,400 employees and dependents may need such assistance at some time. We are therefore encouraged that in providing professional help to 328 employees and dependents to date, we have already reached 20 percent of our potential at-risk population.

Cumulative referral figures indicate that women, minorities and salaried persons are utilizing the program in proportion to their totals in our workforce. A disproportionately higher number of younger workers have used the program in its first three years. The 328 program participants have manifested a variety of presenting problems including drug and alcohol abuse (24%), emotional problems (26%), marital difficulties (18%), family problems (10%) and legal, financial, medical and other difficulties (22%). The variety of referral sources responsible for these referrals suggests that a network of program supporters is developing. Unions, Medical staff, Industrial Relations and friends have each been responsible for 5 percent of program referrals. Families and supervisors have each referred 13 percent, while 54 percent of the referrals have been self-initiated. Most of the program participants have needed additional outside professional services, and 81 percent of those persons have accepted referral to various community resources.

Our experience parallels that of other industries with between 55 to 65 percent of the program participants reporting fewer health, job and family problems after referral to Self Help. We have witnessed a dramatic reduction in absenteeism among most alcoholic program participants, who typically experience an average of 22 days of absence annually prior to treatment. Grievances and disciplinary actions have been sharply reduced among many program participants, while over half of the alcoholic employees who have received treatment have reduced their accident rates by nearly 35 percent.

Definitive results of the impact of our Self Help Program are not yet available, for we need to isolate the net impact of the program on worker health and behavior, from the effects of safety incentive campaigns, changes in time and attendance policies and the reduction of total work hours over the past three years. But we can see from these preliminary indicators that human suffering and employee turnover is down, while dollars are being saved and productivity is being served. We are encouraged by these early signs, and intend to redouble our efforts in the years ahead.

In closing let me say that I am pleased to be associated with a human service venture which works as well as our Self Help Program. I believe that employee assistance programming has worked well for us because of the strong internal commitment and support we have received from the very highest levels within our organization. Without it I would have had significantly less dramatic results to report to you today. At Stroh I have experienced a commitment to employee assistance and worker health that not only manifests itself locally, but also nationally in the form of support for the publication of the United States Brewers Association manual on EAP's entitled Employee Assistance Program: A Model, sponsorship of an investigation of the treatment and recovery needs of alcoholic executives and salaried personnel through the Association of Labor Management Administrators and Consultants on Alcoholism, and financial support for a variety of state and national conferences and projects aimed at favorably impacting the problems of troubled employees across the nation. It is a pleasure to be a part of that Corporate commitment.

I am pleased to have had the opportunity to share our experiences with employee assistance programming with you today, and would be glad to answer any questions you might have about our efforts in Detroit, Michigan.

Thank you.

The Stroh Brewery Company

SELF-HELP PROGRAM

A Service to Employees and Their Families

The Stroh Brewery Company
Detroit, Michigan 48226
ONE STROH DRIVE
FORMERLY 909 EAST ELIZABETH STREET
(313) 961-5840

STROH'S BOHEMIAN BEER
STROH'S ICE CREAM

ESTABLISHED 1850

August 1, 1979

Dear Stroh Employee and Family:

The most important asset of The Stroh Brewery Company is its employees. We strive to provide benefits to employees and their families that will help to improve and maintain the quality of their lives.

The Company recognizes that all of us are beset with personal problems from time to time that not only disrupt work, but affect enjoyment of life both on and off the job. We believe, however, that most human problems are treatable and solvable with the timely provision of professional help. Therefore, to assist employees and their family members in getting quality help in times of stress, we have established the Stroh Self-Help Program. A professionally trained program coordinator is available to serve as a bridge between employees searching for relief from problems and quality community resources ready to help. We urge employees and their families who are experiencing difficulties to contact the program for confidential assistance at 567-0031.

Hopefully, through the provision of such a service, our lives at work and home will grow to be richer.

Sincerely,

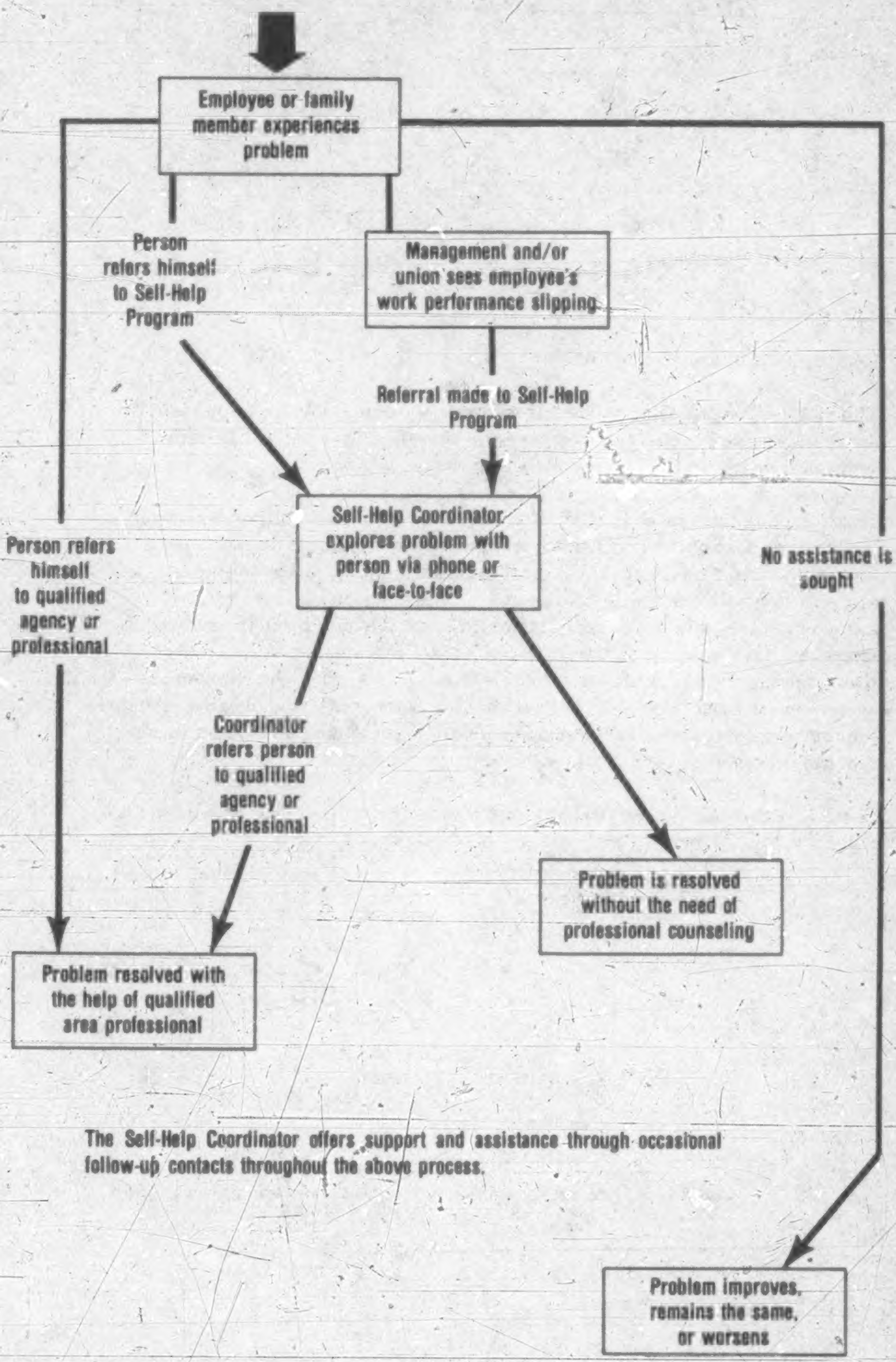
Peter W. Stroh

Peter W. Stroh
President

PWS/sjm

ADDRESS ALL COMMUNICATIONS TO THE COMPANY—NOT TO INDIVIDUALS

HOW THE SELF-HELP PROGRAM WORKS


Employee or family member experiences problem
Person refers himself to Self-Help Program
Management and/or union sees employee's work performance slipping
Referral made to Self-Help Program
Self-Help Coordinator explores problem with person via phone or face-to-face
Person refers himself to qualified agency or professional
No assistance is sought
Coordinator refers person to qualified agency or professional
Problem is resolved without the need of professional counseling
Problem resolved with the help of qualified area professional
Problem improves, remains the same, or worsens

The Self-Help Coordinator offers support and assistance through occasional follow-up contacts throughout the above process.

QUESTIONS FREQUENTLY ASKED ABOUT THE SELF-HELP PROGRAM

WHAT HAPPENS WHEN I GO TO THE SELF-HELP PROGRAM?

You and/or your family member will talk with the program coordinator in a relaxed, confidential setting at a time convenient to you. He will help you explore the circumstances surrounding the problem and when appropriate suggest quality resources in the community which are eager to help. At your request, he will contact agencies to arrange appointments and follow-up with them to make sure you receive the help you need.

WHAT KIND OF PROBLEMS IS THE PROGRAM EQUIPPED TO HANDLE?

The Self-Help Program can help employees and their families who are experiencing a wide range of personal problems, including emotional upset, alcoholism, marriage and family difficulties, drug abuse, and financial troubles. We believe that almost any human problem can be dealt with when identified and treated early. Fortunately our community contains a broad range of qualified professional persons who can help with most personal problems. Our program coordinator is in close touch with these resources.

WHAT KIND OF HELP CAN I EXPECT FROM THE SELF-HELP PROGRAM?

The program coordinator is prepared to:

1. Help you get a better picture of the nature of your problem.
2. Talk with you about the advantage of various community resources.
3. Guide you toward the best resource to help you with your particular problem.
4. Provide confidential, personalized attention to your needs.
5. Talk to your family when necessary.
6. Follow up with agencies to make sure you receive quality assistance.

WHY HAVE A SELF-HELP PROGRAM? CAN'T PEOPLE HANDLE THEIR OWN PROBLEMS?

The main reason that we have such a program is to simplify things for employees and their families. Few of us are familiar with the many sources of assistance in our community. Often we know *what* our problems are, but are unsure as to *where* to find solutions. Other companies have found that the best way to get help to employees in need is to utilize a professional, skilled in the resources of the community to provide a bridge between workers and community assistance. We at Stroh's believe our employees deserve such an important service.

IF I USE THE SELF-HELP PROGRAM WHO KNOW ABOUT IT AND WHO KEEPS THE RECORDS?

All visits with the program coordinator are fully confidential. Appointments can be arranged at several locations on plant premises to insure privacy. Only you and your counselor know about your case, unless *you* choose to discuss it with others. Records are kept under lock and key in the program coordinator's office. No other person will have access to the names and records of people who seek assistance. Your records and use of the program is kept strictly confidential.

HOW DOES MY SUPERVISOR OR UNION REPRESENTATIVE FIT INTO THE PROGRAM?

Your supervisor will offer his help, too. Like many of us, he is interested in your welfare. He knows that "straighten up or get out" is not the only way to approach people's problems. But, until now, he has had little other choice. Now, however, the Self-Help Program is available to which he can refer employees for help. Your supervisor will not try to diagnose your particular problem or problems. His concern is with your job performance. He will, however, encourage you to contact the Self-Help Program if you show evidence of having some problem, and he will continue to do his job of keeping track of your productivity, absence, punctuality and general work performance. If you refuse help and your work is unsatisfactory, your supervisor has no alternative but to follow through with disciplinary action.

Also, your union representative is interested in you and wants to help you. He too will assist you in going to the Self-Help Program if you ask his help or appear to be having a problem. You can, of course, contact the program coordinator on your own, without being referred by anyone.

DOES THE SELF-HELP PROGRAM CHANGE THE GRIEVANCE PROCEDURE? CAN MY USING IT AFFECT MY STANDING WITH THE COMPANY?

The creation of the Self-Help Program has not changed, altered, or modified disciplinary procedures in any way. There is no direct connection between program participation and formal grievance procedures. One's future with the Company continues to be based on satisfactory performance of work duties. If one's work performance has been affected by personal problems, Self-Help assistance might help reduce these problems. As problems decrease and work performance improves, the likelihood of discipline decreases and one's standing with the Company improves. Participation in the program is not noted in one's personnel file.

POLICY STATEMENT
STROH BREWERY SELF-HELP PROGRAM

INTRODUCTION

The Stroh Brewery Company and the Unions representing Stroh employees have agreed to work cooperatively in the development and implementation of a program to provide employees who may encounter personal problems with constructive and professional guidance. A committee having equal representation from Labor and Management has been formed to coordinate and evaluate the program. It is understood that the committee, as a body, shall have no power or authority to change, alter, or modify the collective bargaining agreements between the Company and the Unions.

The program is designed to deal with alcoholism, drug abuse, or other personal situations (such as family, marital, financial, mental health problems, and drug addiction). We are concerned with the employee's physical and emotional health and morale. We are equally concerned because problems of this nature may adversely affect any employee's safety, attendance, punctuality, and job performance. Both Union and Management believe that constructive measures are available to deal with these matters.

I. OBJECTIVE

This joint effort is intended to help employees who are troubled by personal difficulties to seek assistance to control the condition itself, before it renders them unemployable. Employees are encouraged to request assistance personally.

The Company and the Unions will work together to establish a system for early identification of employee's problems and for referral of the employee for counseling or other proper treatment. Referral to the program will be based on declining job performance.

II. POLICY FOR ADMINISTRATION

The Company and its Unions have formed a joint committee to ensure cooperation in providing assistance to employees with personal problems. This committee will engage in a continuing effort to formally develop a Company-wide program involving all levels of Management and Union personnel. The committee will secure the services of a program coordinator to encourage employees to seek outside assistance, and obtain the assistance of recognized outside resources. The committee will also devote its attention to the following objectives:

1. Generate a climate which will eliminate any effects of the social stigma associated with alcoholism, drug abuse, and personal problems. This stigma often acts as a serious barrier to constructive correction action. This policy is not concerned with non-problem drinking. The Stroh Brewery and the Unions recognize that treatment of alcoholism, drug abuse, and personal problems, is in the best interest of the worker, Unions, and Company.
2. Encourage Management and Union personnel at all levels to exercise their best efforts toward the objective of early identification and motivation of employees to seek tratment and rehabilitation.
3. Encourage employees who have problems to voluntarily seek assistance through the use of this program. Employees may be referred to the program on the basis of deteriorating job performance. Compliance with the referral will be voluntary. It is the aim of the program to assist employees in resolving their personal problems.

4. Ensure strict confidentiality and private handling of all aspects of the program.
5. Recognize that any employee who seeks the help of the program will not jeopardize job security or promotional opportunities by doing so.
6. Assist in providing and developing training, educational, and informational materials for use in the program.

III. ACKNOWLEDGMENTS

The Company and its Unions acknowledge that:

1. The program is intended to provide the employee with an opportunity to identify and correct his, or her, problem before disciplinary action becomes necessary or before it results in discharge. The program is not an alternative to disciplinary action and nothing in this policy statement shall limit Management's right to invoke disciplinary action subject to the terms and provisions of the collective bargaining agreement between the Company and the Unions, nor the Union's right to process grievances concerning such disciplinary measures in accordance with individual collective bargaining agreements.
2. Persons participating in this program will be expected to meet personal job performance standards and standard personnel practices.
3. When it is found that an employee must undergo medical treatment, benefits for that employee will be covered in accordance with existing Stroh Medical Plan.
4. Any counseling or treatment recommended through the program will be conducted in a private and confidential manner in the best interests of the employee, Company, and Unions. It is understood that staff members of the program will not participate in any discipline, grievance, or arbitration procedure involving program participants.
5. Participation in the program by an employee shall be voluntary and the determination to utilize any recommended outside source for treatment or counseling shall be the sole responsibility of the employee.
6. It is the intent of the Company and the Unions to make this a continuing program; however, the Company and the individual Unions unilaterally reserve the right to withdraw from the program.

Peter W. Stroh

Peter W. Stroh
President

Gerald L. Harper

Gerald L. Harper
Teamsters Local Union No. 181

Robert E. Knox

Robert E. Knox
Teamsters Local Union No. 1038

James D. Leslie

James D. Leslie
IAM Local Union Lodges No. 82 & 698

David V. Van Howe
Vice President-Administration & Secretary

George L. Kresin

George L. Kresin
Director of Industrial Relations

Curt M. Russell

Curt M. Russell
Director of Human Resources

IF YOU WOULD LIKE FURTHER INFORMATION

The coordinator for this program is Bob Inskeep. You can reach Bob on his private line — 567-0031. A 24-hour telephone answering machine will take a message, or provide you with further information if Bob is away from his desk. His office is located next to the personnel department in the Goebel warehouse building. If you would like more information about the Self-Help Program, call Bob or ask your supervisor or union steward.

Senator **Quayle**. Thank you. Dr. Reitan?

Dr. **Reitan**. Chairman Quayle, I am Harry Reitan of the Adolph Coors Co. in Golden, Colo. I thank you for the opportunity to discuss a problem that is of great concern to all of us; namely, alcohol abuse.

I have with me Ben Mason, who is a consultant to the Adolph Coors Co. in our alcohol task force. I have provided a written statement for the record. My comments will highlight some of the issues that are raised in that written statement.

Coors has had an informal employee assistance program for years and a formal employee assistance program for 10-plus years. I will not dwell on that element of our overall program because I think there has been a good bit of testimony with regard to employee assistance programs.

I might say that our employee assistance program is as successful as most. The penetration rate last year was 6 percent of employees and 1 percent of dependents. The problem that we see with employee assistance programs, per se, is that they probably are limited to dealing with problem employees or dependents after the problem has come to full bloom and is fully entrenched.

Given that, we have embarked on a relatively ambitious proactive, preventive wellness program that is available to all employees, all retirees, spouses, and dependents 16 years of age and older.

The assumptions underlying the wellness program are that individuals have the primary responsibility for their own level of wellness. I might add that our society has significantly diffused the responsibility for health and well-being. Practitioners are held responsible; insurance programs are held responsible; Federal and State agencies are held responsible; employers are held responsible.

The individual within that health care maze is charged with very little responsibility, and we feel that there is no agency and no individual in the health care system who has more to gain and more control over wellness and more to lose from illness than that particular individual, and we feel that is where the responsibility must be firmly established.

A related assumption is that many individuals are neither psychologically prepared nor equipped with sufficient information and knowledge to fully accept responsibility for their own health and well-being.

The third assumption is that wellness is reflected by a choice in lifestyle. Those assumptions are the basis for the structure and the concept of our wellness program. We have six modules. The core module is physical fitness; related modules are alcohol—everybody's business; nutrition; stress management; weight control; and smoking cessation. Each of these modules is self-contained and can stand alone, but each contains elements of the other modules.

Therefore, with all modules under one roof, we are getting a synergistic effect, and the collective program is an overall stress management program.

The response to the wellness program, which is a year old as of last month, has been enthusiastic and positive. We have conducted over 3,700 health screens on a voluntary basis. That represents just over 25 percent of those who are eligible. We have experienced

63,000-plus individual uses of the center. That translates to an average of about 300 users per day, and that figure is growing.

I would like to touch on the module that is pertinent to this committee, and that is "alcohol—everybody's business." That module is targeted on the "average" adult. It is not a treatment program. Those individuals within Coors and their dependents who are candidates for conventional alcohol treatment programs are referred to programs in the Denver metropolitan area.

The program is a unique, proactive, problem prevention approach designed to inform and educate individuals with regard to alcohol and its use and effects. It teaches participants a technique called situational analysis. It allows individuals to evaluate their drinking behavior—where, how, why, and with whom they drink. The main thrust is to identify alternatives to questionable drinking patterns and ways to implement those alternatives. The bottom line is to provide an environment that encourages lifestyles compatible with maximum well-being.

There are two other programs that Coors is involved with, and I would like to briefly mention them. Coors is supporting and helping sponsor the wellness program at the Colorado School of Mines. There are two objectives to that program. One is to meet the specific needs of the students at the Colorado School of Mines. Another objective is to develop a low-cost preventive program which can be used on other college campuses.

This 3-year applied research project has 1 year behind it. That year was devoted to development and planning. The operational guidelines and original materials will be available for dissemination in 2 years.

A second program we are supporting is the Center for Applied Prevention Research. It addresses substance abuse in the school systems both at the primary and secondary levels. The Center for Applied Prevention Research is working with the Colorado Association of School Executives, responding to defining the problem—responsibilities, roles—and identifying what has been effective, who can help, and how.

Mr. Chairman, in summary, the Adolph Coors Co. is aggressively developing concepts and programs that are preventive and which encourage individuals to choose wellness lifestyles. We cordially invite you and the committee members to Golden, Colorado to examine our program on a firsthand basis. We feel such a visit would be invaluable to the members of the Committee when you finally consider legislative alternatives. Thank you very much.

[The prepared statement of Dr. Reitan and additional statements and material supplied for the record follow:]

STATEMENT OF:

DR. HARRY REITAN,
MANAGER HEALTH SERVICES
ADOLPH COORS COMPANY

BEFORE

THE ALCOHOLISM AND DRUG ABUSE SUBCOMMITTEE AND THE EMPLOYMENT AND PRODUCTIVITY SUBCOMMITTEE OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON

ALCOHOL AND DRUG MISUSE
AND THEIR AFFECT ON PRODUCTIVITY

JULY 14, 1982

MR. CHAIRMAN, I AM DR. HARRY REITAN, MANAGER HEALTH SERVICES, OF THE ADOLPH COORS COMPANY. I WISH TO THANK YOU FOR THE OPPORTUNITY TO ADDRESS THIS COMMITTEE ON A SUBJECT WHICH IS A GREAT CONCERN TO ALL OF US -- ALCOHOL ABUSE.

ADOLPH COORS COMPANY IS FIRMLY COMMITTED TO DEVELOPING AND PUTTING INTO MOTION PROGRAMS WHICH WILL ALLOW PEOPLE TO BOTH AVOID AND OVERCOME BEVERAGE ALCOHOL-RELATED PROBLEMS.

SINCE ITS BEGINNING IN 1873, ADOLPH COORS COMPANY HAS BEEN DEDICATED TO BREWING THE HIGHEST QUALITY AND MOST SATISFYING BEER POSSIBLE FOR ADULTS OF LEGAL DRINKING AGE. THIS DEDICATION IS EVIDENCED TODAY IN THE COMPANY'S ADVANCED AND LENGTHY BREWING PROCESS WHICH USES ONLY NATURAL INGREDIENTS OF THE HIGHEST QUALITY. THE RESULT IS THE PUREST BEER ON THE MARKET TODAY--BEER WHICH THE COMPANY CAN PROUDLY SAY CONTAINS NO ADDITIVES OR ARTIFICIAL PRESERVATIVES. NOTHING IS SPARED IN THIS COMMITMENT TO BREWING THE FINEST PRODUCT POSSIBLE.

WHILE COORS' MALT BEVERAGE PRODUCTS ARE USED BOTH WISELY AND WITH SATISFACTION BY MOST OF ITS CONSUMERS, THE

COMPANY RECOGNIZES THE POTENTIAL FOR HARM THAT CAN RESULT FROM THE MISUSE OF ANY PRODUCT. AND, AS A BREWER, IT IS GRAVELY CONCERNED ABOUT HARM THAT RESULTS FROM THE MISUSE OR ABUSE OF BEVERAGE ALCOHOL.

WHY SOME MISUSE OR ABUSE ALCOHOL: INABILITY TO COPE

WHILE OUR MODERN SOCIETY PRESENTS US WITH MORE CHOICES AND OPPORTUNITIES THAN EVER BEFORE, IT ALSO LEAVES US CARRYING AROUND HIGH, OFTENTIMES UNHEALTHY LEVELS OF STRESS. WHILE MANY LEARN TO SUCCESSFULLY COPE WITH THESE STRESS OVERLOADS, OTHERS TURN TO ALCOHOL OR OTHER SUBSTANCES FOR RELIEF.

ALTHOUGH THERE ARE MANY REASONS WHY INDIVIDUALS MISUSE OR ABUSE BEVERAGE ALCOHOL, ADOLPH COORS COMPANY BELIEVES THE INDIVIDUAL'S INABILITY TO CONSTRUCTIVELY MANAGE THE STRESSES IN HIS OR HER LIFE TO BE A MAJOR FACTOR.

WHEN USED TO MANAGE STRESS, ALCOHOL CAN BECOME A FAULTY COPING MECHANISM. LIKE OTHER SIMILAR CRUTCHES USED TO MANAGE STRESS, EXCESSIVE AND PROLONGED USE OF ALCOHOL IS HAZARDOUS TO ONE'S HEALTH.

IN THE BOOK, THE AMERICAN WAY OF LIFE NEED NOT BE HAZARDOUS TO YOUR HEALTH, AUTHOR JOHN W. FARQUHAR, M.D. SAYS THAT MOST OF US SIMPLY DO NOT KNOW HOW TO COPE WITH STRESS.

BUT FORTUNATELY WE CAN DO SOMETHING ABOUT IT, SAYS FARQUHAR. "MANAGING STRESS EFFECTIVELY IS A LEARNED SKILL--A SKILL THAT IS OF BASIC AND VITAL IMPORTANCE TO OUR GENERAL WELL-BEING AND OUR ABILITY TO LIVE FULLY AND PRODUCTIVELY IN A STRESS-FILLED WORLD," HE WRITES.

ADOLPH COORS COMPANY'S PHILOSOPHY ON STRESS MANAGEMENT PARALLELS FARQUHAR'S MESSAGE. THE COMPANY IS THEREFORE ACTIVELY PROMOTING PROGRAMS THAT ENCOURAGE INDIVIDUALS TO APPLY CONSTRUCTIVE STRESS MANAGEMENT PRINCIPLES TO THEIR LIVES, THEREBY PROVIDING POSITIVE ALTERNATIVES TO THE MISUSE OR ABUSE OF BEVERAGE ALCOHOL.

WHEN GIVEN THESE ALTERNATIVES TO ALCOHOL MISUSE AND ABUSE, ADOLPH COORS COMPANY FIRMLY BELIEVES THE INDIVIDUAL CAN MAKE INTELLIGENT AND RESPONSIBLE DECISIONS ABOUT THE USE OF ALCOHOL. THIS PHILOSOPHY CONTRASTS WITH THE POSITIONS OF THOSE WHO SUPPORT UNREASONABLE RESTRICTIONS, HIGHER PRODUCT PRICES, HEALTH WARNINGS AND THE LIKE TO

OVERCOME THE PROBLEM. THROUGHOUT HISTORY, THESE KINDS OF RESTRICTIVE MEASURES HAVE PROVEN INEFFECTIVE, SINCE THE REAL SOURCE OF ALCOHOL MISUSE LIES WITHIN THE INDIVIDUAL PERSON NOT THE PRODUCT.

THE EDUCATION COMMISSION OF THE STATES, IN A RECENT REPORT IT COMPILED ON THE RESPONSIBLE USE OF ALCOHOL, ECHOES COORS' PHILOSOPHY. "OUR ONLY HOPE OF REDUCING ALCOHOL-RELATED PROBLEMS," CONCLUDES THE REPORT, "IS TO RECOGNIZE THAT THE DECISIONS WE MAKE ABOUT ALCOHOL ARE A PART OF OUR EVERYDAY LIVES, AND THEY REFLECT OUR ABILITY TO MAKE RESPONSIBLE DAY-TO-DAY DECISIONS ABOUT MANY OF LIFE'S CHALLENGES AND ALTERNATIVES."

THE COMMISSION ALSO STRESSES THAT THE SKILLS AND ATTITUDES, BASED UPON KNOWLEDGE, THAT ARE NECESSARY TO MAKE RESPONSIBLE DECISIONS ABOUT ALCOHOL CAN BE IDENTIFIED AND LEARNED.

DEDICATION TO WELL-BEING

BECAUSE ADOLPH COORS COMPANY IS COMMITTED TO HELPING PEOPLE BOTH AVOID AND OVERCOME ALCOHOL-RELATED PROBLEMS, THE COMPANY IS NOW CREATING PROGRAMS FOR COORS EMPLOYEES

AND SUPPORTS MANY ORGANIZATIONS THAT AFFECT THE GENERAL PUBLIC.

COORS EMPLOYEES WITH ILLNESSES CAUSED BY ALCOHOL ABUSE ARE REFERRED TO A COMPREHENSIVE HEALTH CARE PROGRAM.

BUT THE COMPANY HAS RECENTLY TAKEN ON A MUCH MORE PROACTIVE, PREVENTIVE POSTURE ON THE ISSUE OF ALCOHOL MISUSE AND ABUSE, RELATING IT DIRECTLY TO STRESS MANAGEMENT AND TOTAL WELL-BEING.

THE AIM IS TO TEACH EMPLOYEES AND THE PUBLIC THE PRINCIPLES OF STRESS MANAGEMENT, IN ORDER TO PREVENT THE NEED FOR HEALTH-DAMAGING CRUTCHES. THESE PRINCIPLES ARE: GOOD NUTRITIONAL HABITS, ADEQUATE AEROBIC EXERCISE AND TRAINING THE MIND TO DEVELOP A FAST RELAXATION RESPONSE TO STRESS STIMULI.

WILLIAM K. COORS, CHAIRMAN AND CHIEF EXECUTIVE OFFICER OF ADOLPH COORS COMPANY, HAS STATED ON VARIOUS OCCASIONS THAT "IF AGENCIES AND ORGANIZATIONS INVOLVED IN REHABILITATING ALCOHOLICS WOULD INCORPORATE THESE STRESS MANAGEMENT PRINCIPLES IN THEIR TREATMENT PROCESSES, IF SCHOOLS WOULD INCLUDE THEM IN THEIR CORE CURRICULUMS, AND

IF EMPLOYERS WOULD ESTABLISH STRESS MANAGEMENT CENTERS TO SERVE THEIR TROUBLED EMPLOYEES, SOCIETY WOULD BE WELL ON ITS WAY TO RESOLVING THE ALCOHOL ABUSE PROBLEM."

IN LINE WITH THIS PHILOSOPHY, IN JUNE 1981 THE COMPANY OPENED THE COORS WELLNESS CENTER TO ENCOURAGE AND ALLOW ITS 9,000 EMPLOYEES AND THEIR DEPENDENTS TO ADOPT LIFESTYLES AND HABITS THAT PARALLEL GOOD HEALTH. THE WELLNESS CENTER FEATURES CLASSES ON ALCOHOL MISUSE AND ABUSE, SMOKING CESSATION, NUTRITION, STRESS MANAGEMENT, WEIGHT CONTROL AND FITNESS, AND INCLUDES SOPHISTICATED AEROBIC EXERCISE EQUIPMENT, WEIGHT MACHINES AND A JOGGING TRACK.

WHILE USE OF THE WELLNESS CENTER IS NOT MANDATORY FOR ANY EMPLOYEE, CLASSES ARE WELL-ATTENDED AND ACTIVITY TAKES PLACE THERE FROM 5:30 A.M. TO 10 P.M. DURING WEEKDAYS AND IS OPEN ON WEEKENDS.

IN THE COMMUNITY, COORS IS INVOLVED IN AN ALCOHOL RESEARCH PROJECT WITH THE COLORADO SCHOOL OF MINES. THE PROGRAM HAS THE GOAL OF TEACHING STUDENTS HOW TO COPE IN A HIGHLY STRESSFUL ACADEMIC ENVIRONMENT WITHOUT ABUSING ALCOHOL.

THE COMPANY ALSO SUPPORTS BOTH PRIVATE AND PUBLIC ORGANIZATIONS THAT CONTRIBUTE TO THE PREVENTION OF HEALTH PROBLEMS RESULTING FROM THE MISUSE OF ALCOHOL AND OTHER SUBSTANCES.

WHAT CAN I DO?

THOSE OF US WHO CHOOSE TO ENJOY ALCOHOLIC BEVERAGES MUST ASSUME PERSONAL RESPONSIBILITY FOR OUR OWN WELL-BEING. THOSE PEOPLE WHO ALREADY HAVE ALCOHOL-RELATED PROBLEMS OR ILLNESSES SHOULD BE TREATED IN A COMPREHENSIVE HEALTH CARE PROGRAM.

EDUCATION PROGRAMS THAT INCREASE THE AWARENESS THAT ALCOHOL MISUSE CAN BE PREVENTED SHOULD BE AIMED AT THE GENERAL PUBLIC, BUSINESS AND INDUSTRY, THE NEWS MEDIA AND SCHOOLS TO ENABLE PEOPLE TO MAKE INTELLIGENT JUDGMENTS REGARDING ALCOHOL USE AND THE PRACTICE OF CONSTRUCTIVE STRESS MANAGEMENT AS AN ALTERNATIVE.

BY LEARNING HOW TO EFFECTIVELY COPE WITH THE LARGE AMOUNTS OF STRESS IN OUR LIVES, WE FIND VIABLE ALTERNATIVES TO THE USE OF ALCOHOL OR OTHER SUBSTANCES AS A MEANS OF RELIEF. WITH THIS KNOWLEDGE IN MIND, EACH OF

US CAN BECOME INVOLVED IN PROGRAMS IN OUR COMMUNITIES THAT TEACH STRESS MANAGEMENT THROUGH THE PRINCIPLES OF AEROBIC EXERCISE, NUTRITION AND MIND RELAXATION TECHNIQUES.

MR. CHAIRMAN, I HOPE THIS BRIEF REVIEW OF THE ADOLPH COORS COMPANY'S ANALYSIS OF ALCOHOL MISUSE AND PROGRAMS WHICH WE HAVE DEVELOPED TO ELIMINATE THIS DEPENDENCY WILL BE HELPFUL TO THIS COMMITTEE AND CONGRESS IN REVIEWING VARIOUS PROPOSALS TO REDUCE THE MISUSE AND ABUSE OF ALCOHOL IN OUR COUNTRY. I HAVE ALSO ATTACHED FOR YOUR INFORMATION A COPY OF THE COMPANY'S OFFICIAL ALCOHOL MISUSE AND ABUSE POLICY. THIS POLICY STATEMENT SUMMARIZES ADOLPH COORS COMPANY'S POSITION CONCERNING ALCOHOL MISUSE AND ABUSE.

FINALLY IN CLOSING, WE CORDIALLY INVITE YOUR COMMITTEE TO GOLDEN, COLORADO TO EXAMINE OUR PROGRAMS ON A FIRST-HAND BASIS. WE BELIEVE SUCH A TRIP WOULD BE INVALUABLE TO YOUR MEMBERS WHEN YOU FINALLY CONSIDER POSSIBLE LEGISLATIVE ALTERNATIVES.

ADOLPH COORS COMPANY POLICY

ALCOHOL MISUSE AND ABUSE

SCOPE

This policy applies to all companies within Coors Industries, setting forth our Company's philosophy, policy and action plan for providing education on and treatment of alcohol misuse and abuse. Alcohol misuse and abuse as defined by our Company occurs when excessive consumption of alcohol impairs a person's work performance and well-being.

PHILOSOPHY STATEMENT

Adolph Coors Company promotes the sale of malt beverages to those adults of legal age who can consume alcoholic beverages without harm to themselves or others. However, our Company recognizes the potential for harm that can result from the misuse of any product and is gravely concerned about harm resulting from the misuse or abuse of beverage alcohol. We are committed to developing and activating programs which enable people to avoid and overcome beverage alcohol related problems.

We believe the individual's inability to manage constructively the stresses in his or her life to be a major factor in alcohol misuse and/or abuse. The excessive and continued use of beverage alcohol or other palliatives which enable the individual to cope for the moment with his or her stresses is hazardous to one's health and potentially harmful to others. Treatment of the illnesses caused by alcohol abuse should be included in a comprehensive medical care program.

We are convinced that the prevention of destructive health practices, including alcohol misuse and abuse, rests with the individual and cannot be accomplished through the unrealistic use of controls and constraints. We believe that individuals will make intelligent decisions about the use of beverage alcohol if provided knowledge and alternatives through an educational approach.

Therefore, it is the policy and intent of Adolph Coors Company to manage the matter of alcohol misuse and abuse as follows:

1) Through promotion of programs aimed at employees, distributors and consumers to both inform and encourage them to apply the principles of constructive stress management to their lives, thereby avoiding their need for health-damaging palliatives. These principles are: (a) good nutritional habits, (b) adequate aerobic exercise and (c) training the mind to develop a fast relaxation response to stress stimuli.

2) Through promotion of educational programs aimed at employees, shareholders, public officials, the news media and the public which increase the awareness that alcohol misuse and abuse can be prevented, and which will enable people to make intelligent judgments regarding the use of alcohol and alternative constructive stress management.

3) Through opposition to restrictions on the advertising and marketing of beverage alcohol and the right of the individual to make his or her own decisions about its use, when these restrictions are ineffective in reducing this misuse and abuse.

RESPONSIBILITY

It shall be the responsibility of all Coors Industries' corporate directors and officers to ensure that all company programs involving health and substance misuse and abuse of any kind comply with this policy.

6/19/81

STATE OF NEW YORK
DIVISION OF ALCOHOLISM AND ALCOHOL ABUSE
194 WASHINGTON AVENUE, ALBANY, NEW YORK 12210

SHEILA B. BLUME, M.D.
DIRECTOR

ROBERT A. ROSS
EXECUTIVE DEPUTY DIRECTOR

July 27, 1982

Ms. Nancy Wolicki, Staff Director
Senate Subcommittee on Alcoholism
and Drug Abuse
c/o Sen. Gordon Humphrey
Room 6205 - Dirksen Office Bldg.
Washington, D.C. 20510

Dear Ms. Wolicki:

The Occupational Unit of the NYS Division of Alcoholism is submitting a paper by Walter R. Silver of our staff, to the joint hearing on Employee Assistance Programs for Alcohol and Drug Abuse by the Senate Alcoholism and Drug Abuse Sub-committee and the Employment and Productivity Sub-committee as written testimony.

The paper deals with the high costs paid in human and financial terms which the private and public sector pay for workers with personal problems. Mr. Silver's paper also outlines the rate of funding by NYS for the State governmental level Employee Assistance Program.

We would recommend this paper be included into the Congressional Record.

If there are any questions, please feel free to call Mr. Silver at (518) 474-6422.

Sincerely,

William R. Byers

William R. Byers, CAC, ACSW
Assistant Director
NYS Division of Alcoholism
and Alcohol Abuse
Occupational/Industrial Bureau

cc: Olive Jacob

Walter R. Silver

EMPLOYEE ASSISTANCE PROGRAMS

A SHORT PERSPECTIVE AND CURRENT STATE OF THE ART IN NYS

Industry, labor and governmental organizations are not immune to paying devastating costs, both financial and human, for the numerous personal problems that affect job performance according to the Association of Labor Management Administrators and Consultants on Alcoholism. As many as 10 million Americans are victims of alcoholism and alcohol abuse and their illness affects some 30 million members of their families. Of the nation's 90.5 million employed workers, it is estimated that as many as 7 million have alcohol problems. Alcoholism and alcohol abuse cost the nation nearly $43 billion annually - $19.64 billion attributed to lost production and $12.74 billion to health and medical expenditures as a consequence of alcoholism and related health problems. It is estimated that the cost of treating all alcohol-related problems outweighs liquor revenue by more than four to one.[1]

The Employee Assistance Program is a system designed to identify, motivate for treatment, refer and follow-up with employees when the disease of alcoholism, when alcohol abuse, substance abuse, emotional and mental problems and other behavioral/medical problems interfere with their ability to function on the job. The Employee Assistance Program is located at the work site or in a close proximity to the work site and provides services to employees and family members. The Employee Assistance Program provides a valuable service through early identification of problems that result in poor job performance and in helping the employee and family to select appropriate quality resources in the community for treatment and rehabilitation. The Employee Assistance Program is designed to provide the employee with maximum confidentiality.

More than half of all Americans with personal problems are working people and troubled employees who comprise an estimated 10-15 percent of the work force. Troubled employees have about 2.5 to 5.5 times as many absences from work as the general work force, they constitute a liability to their employers through loss of efficiency, lost time on the job, decision making, accidents, impaired morale of co-workers and deteriorated client service. It is this economic loss, coupled with the belief that the behavioral problems are treatable, that has triggered the concern of major corporations, labor unions and government. This concern has encouraged these basic institutions to develop employee assistance and rehabilitation programs. More than 5,000 such programs are in use and the number is growing.

Early EAP programs had put their emphasis on helping employees who had alcoholic problems. The majority of cost benefit studies therefore reflect this emphasis.

The Journal of Occupational Medicine's breakdown of sickness related absenteeism among alcoholics is indicative of the high personal cost to the employer as well as the company:

FREQUENCY OF SICKNESS-RELATED ABSENTEEISM AMONG ALCOHOLIC VS NONALCOHOLIC EMPLOYEES*

	Number of Absences		Frequency Rate†		Alcoholic vs Nonalcoholic Employees (Ratio)‡
	Alcoholic Employees Group	Control Group	Alcoholic Employees Group	Control Group	
Respiratory infections	294	184	38.5	22.5	1.7
Digestive disorders	215	103	28.1	11.9	2.4
Musculoskeletal disorders	111	48	14.5	5.3	2.7
Virus infections (unspecified)	53	46	6.9	5.2	1.3
Cardiovascular disease	40	23	5.3	2.7	1.9
Accidents	35	11	4.6	1.3	3.5
Alcoholism	26	0	3.4	0	–
Neurological disorders	23	17	3.0	2.0	1.5
Genitourinary disorders	19	34	2.5	3.9	0.6
Mental illness	15	6	2.0	0.6	3.3
Other	75	42	9.8	4.9	2.0
Unknown	78	46	10.2	5.6	1.8
Total	964	588	126.2	66.0	2.0

Note: The period covered in the study was one year. *The alcoholic employees group comprised 764 persons, 168 classified as "known" alcoholics, 344 as "suspected," and 252 as "recovered."

†Frequency rate = $\frac{\text{Number of absences}}{\text{Number of persons}}$

‡$\frac{\text{Frequency Rate, Alcoholic Employees Group}}{\text{Frequency Rate, Control Group}}$

Source: *Journal of Occupational Medicine*, Volume 12, No. 6, June 1970 [2]

In evaluating the benefits of existing private EAP programs, Leven points to a definitive study by Asma, Eggert and Helber of the Illinois Bell Telephone Company that was based on the detailed records of 402 employees for five years before and five years after referral to the rehabilitation program. Seventy-two percent of these employees were considered job rehabilitated, a comparable record to that achieved in other companies. Five years after entry into the program, 63 percent were still working, 58 percent were stated as having good job efficiency and the incidence of sickness disability and accidents had markedly decreased.[3] Summary of Alcoholism Offset Studies of 10 EAP Programs issued by the NIAAA, shows a decline in medical care utilization by employees who had access to the 10 programs (see attachment).[4]

Alander and Campbell who evaluated the results obtained by General Motors Oldsmobile Division stated there was striking improvement in various measures of job performance.

The objective of their project was to show whether or not a drug and alcohol rehabilitation program pays off by reducing overall company costs, lost man hours, grievances, disciplinary actions, accidents, sick leaves and sickness and accident benefits.

The study subjects were 117 hourly workers (111 men, 6 women) who had actively participated in the GM rehabilitation program, which was the sole criteria for selection. Participation ranged from five days to ten weeks. An unmatched control group consisted of 24 male employees who had come to the attention of management and were known to have drug or alcohol-related problems (on/off the job) but who had not volunteered to participate in the program after an initial interview. For both the study and control groups, the evaluation time span was one year before and one year after the participation date (interview date for the control group). The results are impressive in all performance areas.

Alander and Campbell also reported that the annual pre-program wage loss for those in the study group was approximately $463,520, while the wage loss after involvement in the program was $237,176. In contrast, the cost for treating the study group in outside facilities (earmarked in insurance data) was:

Alcohol related	$11,114
Drug related	$ 1,201
(105.26 per participant)	$12,315[5]

J.T. Wrich, in his book, "The Employee Assistance Program", provides the comparative estimate that the average hourly employed problem drinker costs his employer about $5,000 per year, when one considers inefficiency, absenteeism, training of replacements, and excess utilization of employee benefits and support functions. The annual loss will be considerably greater if the alcoholic supervisor, manager and executive are taken into account.

Wrich estimates that the cost of helping all disabled employees (including problem drinkers) under a continuing employee assistance program is about one-tenth the expense of what an alcoholic employee will cost over the long run if the employee does not address himself to the problem.

Wrich states that about 70% of the adult population drinks and about one in 11 who drink has trouble with alcohol as a result. Therefore, in a company of 1,000 employees, about 700 drink, meaning that about 60 are in some phase of alcoholism or problem drinking. Given an average wage of $20,000 per employee, including fringes, and applying the estimate that 25 percent of a problem drinker's salary is wasted due to inefficiency, the cost to the typical company of 1,000 employees without an EAP is approximately $300,000 per year.[6]

In the public EAP sector, research from the Occupational/Industrial Bureau, Division of Alcoholism and Alcohol Abuse and the Governor's Task Force on EAP states that approximately 200,000 employees are listed as NYS employees. This figure represents the total of State employees paid out of all funding sources and is not limited to State workers whose salaries are drawn from State Purposes Funds. As of August, 1981, the average salary of State workers was $15,795 using an estimated six percent of the work force as alcoholic and four percent as drug abusers, it is possible to conjecture that at least ten percent of NYS workers are troubled in a way which effects productivity. This is a highly conservative estimate because it does not include employees with other types of problems such as emotional or marital difficulties. Using this estimate, it is possible to say that at least 20,000 State workers are sufficiently disturbed by their personal problems to show declining job performance.

A description of current program funding and sources provided by the EAP Task Force Subcommittee on Program Funding, represents the dollars invested into EAP programs for a three year period.

PROGRAM	FUNDING SOURCE	AMOUNT
*CSEA	OMEP	$ 250,000
CSEA	DAAA	$ 549,000
**PEF	PDQ	$ 100,000
DOT	PDQ	$ 91,000
DOCS	LEAA	$ 45,700
Council 82	GNL	$ 20,713
DSP	DSP Budget	
SUB TOTAL		$1,129,413
***Release Time		$1,789,707
GRAND TOTAL		$2,919,120

*Contributions to the CSEA system underwrite the salaries of the central technical support group and all related training programs. There are 9 persons in this group who serve as Occupational Consultants marketing EAP's to union locals. The salaries alone come to about $546,000 for three years.

**PEF does not have a program as such but has invested this money for the training of PS&T coordinators who work within the CSEA system.

***This figure reflects the release time investment on the part of the agencies which comes to an additional $596,569 per year or $1,789,707 for the duration of the demonstration projects.

Current awareness concerning human capitol investment has shown a marked dividend in raising job performance levels.

SUMMARY OF ALCOHOLISM OFFSET STUDIES

	STUDY	SETTING	TIME AFTER ENTERING TREATMENT	IMPACT ON MEDICAL CARE UTILIZATION (STUDY GROUPS VS. COMPARISON GROUPS)
1.	Philadelphia Police Department (1975)	employee based	1-2 Years	sick days down 38%; injured days down 62%
2.	Philadelphia Fire Department (1975)	employee based	6-12 mos.	sick days down 47%; injured days down 2%
3.	Oldsmobile (1975) (Alander et. al.)	employee based	up to 1 Yr.	33% decline in S&A benefits vs. +66%; and 52% decline in lost manhours vs. +10%
4.	Kennecott (1976)	employee based	unclear	48% decline in hospital, medical and surgical costs vs. +6%
5.	ATC (1976) (JMK International)	ATC's	6th mo.	reduction in hospitalization pointed to total health care savings of more than $1,000 per client
6.	G.M. of Canada (1976)	employee based	up to 1 Yr.	48% decline in S&A benefits vs. +120%; and 64% decline in WC benefits vs. +77%
7.	California Pilot (1977) (Holder)	employee based	3-20 mos.	$.41 savings in general health care expenditures for every $1.00 spent on alcoholism treatment (26% reduction in health utilization)
8.	U.S. Navy (1977) (Edwards et al)	rehab. program	2 years	hospital days down 69%; all illness diagnosis down 79%
9.	Illinois Bell (undated) (Hilker)	employee based	5 years	cases of sickness disability down 46%
10.	Arizona Health	HMO	1 year	40% reduction in costs due largely to hospitalization out of plan referrals and emergency care utilization; and 60% reduction in costs for spouse of alcoholic clients in non-alcoholism services

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Cummins Engine Company, Inc.
Box 3005
Columbus, Indiana
47201

June 8, 1982

Ms. Nancy Wolicki, Staff Director,
Senate Subcommittee on Alcoholism & Drug Abuse
c/o Sen. Gordon Humphrey,
Rm. 6205 Dirksen Office Bldg.
Washington, DC 20510

Dear Ms. Wolicki:

In response to your call for written testimony for the record of the hearing scheduled to start at 10 a.m., July 14, found in the June 30, 1982 issue of "The Alcoholism Report". As President of the National Association of Alcoholism Counselors and Manager of Cummins Engine Company, Inc. Employee Assistance Program, I would like to share the results of a cost benefit study we have done here at Cummins. See attachment.

We were able to realize a $71/month cost reduction on the average for each of the first 392 people to go through our Employee Assistance Program. The Company's Director of Cost Effectiveness is awarding the Employee Assistance Program and staff with wall plaques in recognition of the $334,000 annual savings. His comments were: "In addition, there are benefits (difficult to quantify) of decreased supervision time, lower overtime, fewer swing people, less over-staffing, less inprocess inventories and higher performance".

In addition, as you can see by the attachment there was a very positive impact on absenteeism as well as improved income for the employee and family, which also benefits the community. This one area of cost reduction is but a small piece of the picture, but certainly demonstrates that there is a lot that can be accomplished in assisting business and industry to control costs by the use of Employee Assistance Programs which have a high focus on alcoholism and drug abuse.

Very truly yours,

John F. Brumbaugh CAC, CDC

J.F. Brumbaugh/js   Manager - EAP

Attachment

Phone: 812 372 7211

CUMMINS EAP COST REDUCTION (392 CLIENTS)
Study Period 1/79 - 6/81

Control Group 257 Employees	Supervisor Cost	Absence Cost	Overtime For Absence	Benefits/ Medical Cost	Monthly Average
30 Months	64,355	809,550	40,478	269,850	
Monthly	8	105	5	35	154
Client Group 392 Employees					
PRE EAP 16.22 Months	52,925	2,243,187	112,161	737,556	
Monthly	8	353	18	116	495
During EAP 6.36 Months	20,713	764,391	38,220	755,415	
Monthly	8	307	15	303	633
Post EAP 7.42 Months	24,165	699,382	34,970	139,889	
Monthly	8	240	12	45	306
Pre vs Post EAP					
Per Client Monthly Savings	0	113	6	71	189
Group Monthly Savings	0	44,296	2,352	27,832	74,088

60-65% of these cases were Alcohol problems.
The EAP clients average annual income increased $1,358.00.

STATEMENT OF THE
AMERICAN NURSES' ASSOCIATION
TO THE
SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE
AND THE
SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
ON
ALCOHOL AND DRUG ABUSE AND PRODUCTIVITY
OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

JULY 1982

The American Nurses' Association, the national professional organization representing the nation's nurses, is pleased to submit this statement for inclusion in the record. The relationship between alcoholism and drug abuse and the capacity of individuals to be productive is timely; the Association applauds and commends the subcommittees for their courage and foresight in addressing this issue.

The Association is concerned about the impact of substance abuse on the quality of life of individuals, including nurses, their families, and the community and about the availability, affordability, and accessibility on health care services and restorative programs which are designed specifically to ameliorate these problems. We recognize that alcoholism is a major health problem in the nation and that nurses are not exempted from inclusion in these numbers. Furthermore, we recognize that with the addition of individuals who abuse other substances, such as drugs, as well as the inclusion of individuals with a psychological dysfunction, the resulting total means that a substantial percentage of the population are impaired. The logical conclusion is diminished productivity.

The profession of nursing holds a contract with society for the delivery of safe and effective nursing care to those in need; fulfilling this obligation is of primary importance to ANA. When individuals who misuse alcohol or other drugs or who have a psychological dysfunction are nurses, we are particularly concerned. Our tradition of caring incorporates the concept of personal well-being as key antecedent to ministering to client populations; the wellness of the provider influences the quality and appropriateness of the care provided.

As an association of professionals we cannot and do not abdicate our responsibility to our colleagues and the public; we accept our role of assisting nurses to function at their full professional potential. The realization that providers of health services are included in the numbers who require such services is difficult for any professional group. Until recently we had not taken aggressive steps to provide for data collection about the problem within nursing or to provide assistance for nurses who misuse alcohol and other drugs. At our recent convention in Washington, D.C., the ANA House of Delegates adopted a resolution which directed the Association to support (1) development of national guidelines for establishing programs of assistance, (2) education of nurse administrators and other employers of nurses regarding the impaired nurse, and (3) ongoing collection and dissemination of information.

Self regulation of the profession supports the assurance of quality performance. In order to provide nursing care at a safe level, factors that impede the practitioner's health or create a dysfunctional state must be minimized. In particular, the problem of drug and alcohol addiction and psychological dysfunction impede performance and result in the loss of valuable professional time and resources. Additionally, in the face of increasing demands for nursing services, it is incumbent on the professional association to promote measures that will restore impaired nurses to the work force.

Data about the true extent of the problem within the community of nurses is not known. The National Council of State Boards of Nursing, an organization of those state agencies responsible for licensing practitioners of nursing, reported that 67 percent of state board actions on 971 reported cases in the past year were related to substance abuse. We look forward to the future opportunities, such as hearings of this issue, through which we can reveal the extent of the problem, the explicit relationship of the problem to productivity, as well as the numbers of nurses who have been restored to their personal and professional potentials.

We believe that the broad multifaceted approach to dealing with this issue within the profession is essential. Society cannot and should not be expected to accept less from the nursing profession. Society can and should expect safe and effective nursing services each time the nursing profession is encountered.

As you proceed with understanding and diminishing this dilemma, please contact us; we are willing to share our information when it means that the delivery of health care services will be improved. We have enclosed a copy of the resolution adopted by the 1982 House of Delegates of the American Nurses' Association for your information and review.

AMERICAN NURSES' ASSOCIATION

1982 House of Delegates

Resolution #5 Action on Alcohol and Drug Misuse and Psychological Dysfunctions Among Nurses

(Sponsored by the Division on Psychiatric and
Mental Health Nursing Practice)

Endorsed by the Division on Community Health Nursing Practice

WHEREAS, There are people in the United States among whom are registered nurses whose functioning is impaired because of misuse of alcohol and other drugs or because of emotional and psychological dysfunction; and

WHEREAS, The membership of the American Nurses' Association recognizes its professional responsibility to colleagues and to those they serve; and

WHEREAS, Misuse of alcohol and other drugs and emotional and psychological dysfunction can impair the individual's ability to meet the requirements of the Code for Nurses; and

WHEREAS, Timely and effective intervention can contribute to the restoration to health of the nurse, the maintenance of standards for nursing practice, adherence to the Code for Nurses, and the safety of the public; therefore be it

RESOLVED, That ANA, in collaboration with other health care organizations and interested groups, develop guidelines for establishing programs of assistance and intervention for those nurses whose functioning is impaired because of misuse of alcohol and other drugs or because of emotional and psychological dysfunction; and be it

RESOLVED, That ANA encourage nursing administrators and other employers of nurses to offer appropriate treatment antecedent to disciplinary action in the same manner as with other health problems and to maintain options for continuing or subsequent employment; and be it further

RESOLVED, That ANA establish mechanisms for ongoing collection and dissemination of information, which includes statistical data, status of program implementation, significant educational and research activities, and legal and ethical issues as related to the impaired nurse.

RECEIVED
SENATOR GORDON J. HUMPHREY
1982 JUL 22 PM 4: 37

TESTIMONY ON EMPLOYEE ASSISTANCE PROGRAMS FOR SENATE ALCOHOLISM AND DRUG ABUSE SUBCOMMITTEE AND SENATE EMPLOYMENT AND PRODUCTIVITY SUBCOMMITTEE

PRESENTED BY

EDWARD J. CARELS, PH.D.
VICE PRESIDENT, COMMUNICATIONS
COMPREHENSIVE CARE CORPORATION
NEWPORT BEACH, CALIFORNIA

JULY 14, 1982

- An $8 return for each $1 invested in Employee Assistance Programs
- Reduced use of medical facilities and reduced sick days, ranging from 26 to 69 percent following alcoholism treatment
- Savings of $28,500 in turnover and replacement costs after a hospital instituted an EAP
- Productivity improved by 43 percent among treated alcoholics at Northrup Corp.
- General Motors saves $3,700 per year for employees successfully treated in EAP services

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Improved productivity, reduced absenteeism, reduced hospitalization and medical utilization, better employee morale -- the benefits of Employee Assistance Programs are many and well documented.

I am Dr. Edward J. Carels, vice president of communications for Comprehensive Care Corp., a nationwide health care management organization. We are the nation's largest private provider of treatment for alcohol and related drug problems, caring for some 35,000 patients annually in our hospitals and contract units, CAREUNITS, in community hospitals. Many of our patients are U.S. government employees. We also administer some 15 EAPs, including one for some 14,331 civilian employees in the Pentagon.

We know firsthand that Employee Assistance Programs make sense both for humanitarian and for financial reasons. William P. Daves Jr., chairman of the National Association of Insurance Commissioners Task Force on Alcoholism, Drug Addiction and Insurance, said that "alcohol and drug abuse represent greater losses to business than all other illnesses combined." In 1982 dollars, alcohol and related drug abuse costs industry some $46.9 billion annually. An estimated 10 percent of the work force suffers from alcoholism and problem drinking, and about 1 percent from drug dependency.

EAP services and employer pressure can be critical in convincing an alcohol or drug dependent employee to seek help. In one year of operation, CompCare's Pentagon Employee Referral Service (PERS) helped some 450 employees, 40 percent of whom had alcohol or drug related problems. The vast majority have received treatment and returned to productive work. In a recent study involving some 736 patients at 19 CAREUNITS, 28.3 percent said pressure from their employer was a motivating factor in getting them to seek treatment. More than one-third of these same patients admitted that their drinking had moderately or greatly affected their attendance at work, and 45 percent said it significantly affected their job performance. In the same study, 423 CAREUNIT patients were contacted a year or more following treatment. More than 70 percent of the respondents said their job performance and work attendance were better than they had been prior to treatment. The posttreatment sample of patients reported fewer visits to a physician, fewer hospitalizations, and fewer counseling sessions for nonalcohol-related care.

Despite the demonstrated value of our own and others' EAP services, there is still much which can be done. We recommend:

1) Tax incentives to employers who establish EAP services.

2) Increased efforts of HHS to publicize the value of EAP services.

3) Establishing EAP services for all federal employees and Congress.

4) Restoring the alcoholism rehabilitation benefit under the Federal Employees Health Benefits Program and establishing insurance benefits for alcoholism, drug abuse and mental illness under FEHB that are equal to those of other illnesses.

1) TAX INCENTIVES TO EMPLOYERS TO ESTABLISH EAP SERVICES

HHS Secretary Richard Schweiker in 1981 praised the efforts of employers who were establishing wellness programs for their workers. He talked about the use of tax incentives to encourage others to emulate the prevention pioneers. This same principle can be applied to EAPs which help employees in the early stages of their illnesses when the employees' chances for recovery are the highest. Tax credits would provide incentives to businesses to initiate EAPs. In the long range, government would benefit also, since productive employees pay taxes, whereas unemployed alcoholics and drug abusers place a drain on social welfare programs.

2) INCREASED EFFORTS OF HHS TO PUBLICIZE VALUE OF EAP SERVICES

While the growth of EAP programs in the last decade has been dramatic, many companies still operate in ignorance and deny they have problem employees. Some 43 percent of business executives interviewed in the 1979 Executive Caravan Study conducted by Opinion Research Corporation said their companies did not have a program to identify and help people with drinking problems. Our EAP managers report that some companies reject establishing EAP services, claiming that they carefully screen their employees and therefore have no employees with alcohol or drug problems. Particularly during these difficult economic times, companies seem to be investing in equipment and buildings. They need to be convinced of the cost-effectiveness of investing in their employees' health. The Department of HHS, through its National Institute of Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, National Institute of Mental Health, Office of Disease Prevention and Health Promotion, and the U.S. Surgeon General, can emphasize and publicize the value of EAPs.

3) ESTABLISHING EAP SERVICES FOR ALL FEDERAL EMPLOYEES AND CONGRESS

Dr. William Mayer, ADAMHA administrator, supports Employee Assistance Programs for federal employees (Alcoholism, Jan/Feb, 1982) and we concur. In 1980, government EAPs assisted 20,083 federal employees experiencing emotional disorders, 12,091 suffering from alcoholism, and 1,386 suffering from drug dependencies. These numbers are a small indicator of the number of federal employees who may need or seek help this year. Congressmen and their staffs are not immune to alcoholism, drug dependencies and mental health problems as exemplified by Wilbur Mills and Herman Talmadge.

4) RESTORING THE ALCOHOLISM REHABILITATION BENEFIT UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND ESTABLISHING INSURANCE BENEFITS FOR ALCOHOLISM, DRUG ABUSE AND MENTAL ILLNESS UNDER FEHB THAT ARE EQUAL TO THOSE OF OTHER ILLNESSES.

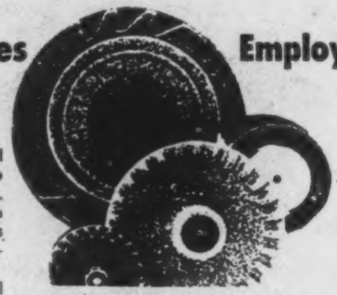
The elimination of the 28-day alcoholism rehabilitation benefit of Blue Cross/Blue Shield's Service Benefit Plan since January of this year has prevented some federal employees and their families from getting adequate care. Reports from our treatment and EAP programs indicate that individuals in the later stages of alcoholism who needed hospital-based treatment and rehabilitation could no longer receive it beyond detoxification because they had no insurance for it and did not have enough in personal funds to pay for it. The reductions in the FEHB program of coverage for nervous and mental disorders and elimination of the alcoholism rehabilitation benefit denies the physician, the mental health professional and the employee assistance professional the opportunity to prescribe the optimal amount and quality of treatment. The real irony here is that untreated alcoholism will bring these people back to the hospital over and over again to deal with the symptomatic results of this disease...liver problems, depression, broken bones, you name it. All at a tremendous cost. The American Medical Association urges that coverage of medical care "not be made on a discriminatory basis based upon the nature of the illness." If reductions in the FEHB program are necessary, the burden should be shared equally by all disease categories. It is unfair for employees suffering from alcohol, drug or emotional problems to carry more than their fair share.

We would also point out that the Federal Government's Merit Systems Protection Board in recent rulings said an alcoholic could not be fired unless the government provided counseling or rehabilitation. Yet if a federal employee's insurance plan does not cover treatment or covers it inadequately, the fact is that the employee is being discriminated against.

Ignoring and slighting treatment for alcohol, drug and emotional problems will not make them go away. These illnesses affect more than 15 percent of the U.S. population and contribute to more than 10 percent of the deaths in this country. It's time the discrimination ended.

Pentagon Escalates Employee Assistance

by Susan Landgraf



The Pentagon Employee Referral Service (PERS) opened its doors to serve the 14,331 civilian employees, plus their dependents, at the Pentagon in Washington, D.C., a short six months ago. But the program is long on enthusiasm and results.

By the end of December PERS had seen more than 200 employees and provided them with diagnosis, limited counseling, and/or referral service, says Jack Sudduth, director. There may be an employee assistance program in the country that's bigger but probably none that has so many people right in one building.

Sudduth, two full-time assistance counselors, an administrative person, and a part-time clinical psychologist try to match employees with the best affordable community resources, including social workers, therapists, psychiatrists, as well as weight loss and phobia clinics and alcohol/drug treatment centers.

In 1980 a task force concluded that an Employee Assistance Program should be established at the Pentagon and that it should be staffed and ~~operated by an outside contracting~~ organization. Comprehensive Care Corporation, a national health care management corporation, contracted with the Department of Defense in July to provide PERS to Pentagon employees.

PERS estimates that 15 percent of the Pentagon's employees have problems, about the same as most businesses. In the first 90 days of operation, one-third of the employees seen by PERS staff had behavioral problems; one-third stress, family, financial, or legal problems; and one-third alcohol/drug related. But Sudduth predicts they'll be seeing more employees with alcohol/drug related problems in the future.

EAP: "Most significant development in the alcohol field since AA originated..."

Alcoholism/the national magazine continues its coverage of employee assistance programs begun in the March/April Special Focus Section: "The EAP Works."

The PERS philosophy is simple. "As with most employee assistance programs, we clearly feel it is far more cost-effective to help folks and to get rid of the problems without getting rid of the folks," Sudduth says.

Some may be like the 19-year-old alcoholic who came into the PERS office in early December and admitted he needed help. He got it promptly. And kept his job. Others may be like the 62-year-old long-time employee who had been drinking for years. No one had steered him to treatment in the past because they didn't want to ruin what was left of his reputation. He was referred to PERS in December by a staff doctor.

"Employee assistance programs may be the most significant development in the alcohol field since AA originated," according to Sudduth.

"The earlier we can get someone, the better," he says.

Employees come in either through self or medical referral, as in the cases above, or through referral by their supervisors. PERS trains supervisors to refer employees in a non-threatening way when their problems show up in poor job performance. Training also emphasizes that PERS provides more than initial diagnosis. Aftercare is important, especially in alcohol/drug related cases, and active cases are reviewed once a week. Some alcoholics get in-patient treatment; others are sent to out-patient programs.

Also, in alcohol/drug related cases it's important supervisors know that when employees get back to their jobs the employees may be better but the recovery process has just begun, he explained. There is no instant cure, and supervisors need to be aware of this fact.

Some employees are suspicious about the program, Sudduth points out. They don't want anything to threaten their jobs or job security. It is a major task to establish a favorable image showing employees that the purpose of PERS is to help them solve their drinking problems, thus improving job performance so they can retain their jobs.

Employees hear about PERS through in-house publications, brochures, posters, and contact people in different agencies and programs. But the best kind of public relations comes from people who have used it and benefitted from it. "Folks are finding out we do good things." PERS is free to Pentagon employees, but they pay the going rates for outside services.

Sudduth sums up his experiences with PERS: "I'm really enthusiastic. I see people being helped here who wouldn't have been helped otherwise." It's the kind of program that should be available to all government employees.

Susan Landgraf — Freelance writer from Renton, WA

Written testimony of:

Stephen K. Lambright
Vice President
Industry & Government Affairs
Anheuser-Busch Companies, Inc.
St. Louis, Missouri 63118

Submitted to:

The Honorable Gordon J. Humphrey
Chairman
Subcommittee on Alcoholism and Drug Abuse
United States Senate
Washington, D.C. 20510

The Honorable Dan Quayle
Chairman
Subcommittee on Employment and Productivity
Unites States Senate
Washington, D.C. 20510

July 29, 1982

My name is Stephen K. Lambright, Vice President of Industry & Government Affairs, Anheuser-Busch Companies, Inc. St. Louis, Missouri.

Anheuser-Busch Companies, Inc. and its wholly-owned subsidiary Anheuser-Busch, Inc. hereby respectfully submit the following written testimony in lieu of an oral presentation before the Senate Subcommittee on Alcoholism and Drug Abuse and the Subcommittee on Employment and Productivity and the Committee on Labor and Human Resources, U.S. Senate.

Anheuser-Busch Companies, Inc. has adopted an employee assistance program for all its employees and their family members and we were the first brewer in the United States to adopt an expansive program of this type. The program has served as a model for other brewers throughout the country.

Anheuser-Busch implemented its program not only to help its employees, but to reduce the expense incurred when employees' problems interfere with their ability to do their job. The program also provides management on all levels with a constructive way to deal with employees with work performance problems.

The company decided not to concentrate solely on alcoholism, but felt it was in the best interest of its employees and their families to offer assistance with any personal problem. The program has been designed to deal with a large variety of difficulties, such as: alcoholism, drug abuse, psychological, marital, and financial problems, as well as other personal difficulties.

The program is designed for Anheuser-Busch and its subsidiaries throughout the United States and includes both employees and their immediate family members (18,000 employees). As of December, 1981, the program was completely implemented (24 sites). Since the program's inception (May 1, 1978 through June 30, 1982) 2,765 persons have used the counseling services.

Utilization figures show that 73% of the people seen were employees and 27% were family members. Sixty-three percent of the employees were hourly employees (craft, operatives and laborers), and 37% were salaried (managers, professional, technical and sales). Forty percent have worked less than five years; 60% have worked from six years to over twenty years. Eighty-five percent of the people seen by the employee assistance program were self referrals and 15% were referred by management. As stated earlier, the program was designed to deal with many kinds of problems. The following is a list of the problem categories as seen by the employee assistance program:

Psychological	32%
Alcoholism/Problem Drinking	23%
Family/Child	14%
Marital	13%
Legal	2%
Drugs	3%
Financial	4%
Other	9%

Most of the cases have been dealt with on an outpatient basis (91%), whereas only nine percent needed to be hospitalized.

The Anheuser-Busch Employee Assistance Program has been highly successful. A study of final disposition of clients seen shows that 70% were improved, five percent had left the company, one percent had deceased, 18% were unimproved; and, as with any study, there were six percent whose disposition was unknown. An amazing 93.7% are still on the payroll; only five percent have left the company, and 1.3% have retired or deceased.

In addition to our internal program we are unique in that we recommend to our 950 independent wholesalers, that they adopt similar programs for their employees. As of this date, approximately 100 wholesalers have adopted an Employee Assistance Program and many others are in the process of adopting a program.

It is clear that even though the Anheuser-Busch Employee Assistance Program has only been in operation for a short time, the benefit to Anheuser-Busch employees has been immeasurable. Approximately 70% of those seen by the Anheuser-Busch Employee Assistance Program are now productive, not only on the job, but in the communities where they live.

Chairman Humphrey and Chairman Quayle, you are both to be commended for taking the initiative to hold Congressional hearings on a serious problem that presently confronts America's industries. Your action here today is certainly in the best interest of industry, employees and the country.

Attached is our corporate position statement on the issue of Alcoholism and Alcohol Abuse published shortly after the inception of our Employee Assistance Program.

Stephen K. Lambright

POSITION STATEMENT ON THE ISSUE OF ALCOHOLISM AND ALCOHOL ABUSE

For well over one hundred years, Anheuser-Busch has operated with a concern for its civic, social and community responsibility, as well as for business purposes.

For those of legal age who elect to drink the malt beverage products we produce, consumed in moderation, afford legitimate pleasure to the user. Indeed, malt beverages have traditionally occupied a respected position in most societies.

Recent years, however, have witnessed a growing awareness and concern on the part of the American public, elected officials and relevant government agencies, as well as the brewing industry, with regard to the problems of alcoholism and alcohol abuse in our society.

The problems of abuse are not inherent in the product itself. The vast majority of those who consume malt beverages do so in moderation.

Nevertheless, Anheuser-Busch is concerned about any abuse of alcohol beverage products and has been dedicated to the support of research, some of which challenges traditional theories, but all of which is being conducted in order to better understand the problem and to provide the basis for more effective programs to combat alcoholism and the abuse of alcohol.

We are concerned about efforts to limit or restrict legitimate channels of distribution and promotion of our products offered in the name of dealing with alcoholism and the abuse of alcohol but which bear no relationship with the problem. These efforts are troublesome for two reasons: first, because they seek to interfere with the legal use of alcohol beverages without resulting benefits in ameliorating alcohol misuse; and secondly, because they are simplistically viewed by many as a panacea for a very complex problem, thereby undercutting the support of critical research and treatment programs.

All such measures that seek to address the problem of alcohol abuse by external manipulation, such as economic sanctions in the form of special taxation, restrictions on advertising, restrictive controls on promotion and warning labels on alcohol beverages of any kind, are opposed by Anheuser-Busch.

On the other hand, Anheuser-Busch supports the proposition that anything less than responsible consumption of alcoholic beverages is detrimental to the individual, to society, and to the brewing industry.

To that end the company has instituted an internal program for the detection and treatment of personnel who misuse alcohol. The knowledge gained from this program will be used to develop a model to be offered for use by others in industry. Further, we are prepared to cooperate in rational educational efforts designed to point out the hazards that may result from the immoderate use of alcohol beverages and will continue our support of traditional research and expand our participation in the development of emerging concepts designed to provide long-term remedies for the problems of misuse.

AUGUST A. BUSCH III
CHAIRMAN OF THE BOARD
AND PRESIDENT

January 26, 1979

STATEMENT

of the

UNITED STATES BREWERS ASSOCIATION, INC.

to the

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

and the

SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

July 30, 1982

The United States Brewers Association, Inc. (USBA), founded in 1862, is our nation's oldest trade association in continuous existence. Member companies include American producers of malt beverage products, suppliers from allied businesses and agriculture, as well as foreign brewers.

Chairman Humphrey and Chairman Quayle, you are to be commended for scheduling public hearings to discern the impact alcoholism and drug abuse has on American productivity. USBA is pleased to submit this written statement on the activities already undertaken by this Association to assist in the further establishment of worksite programs to identify and treat employees troubled by alcoholism, drug abuse, or other personal difficulties.

Alcohol misuse is an issue of deep concern to the brewing industry. Recognizing that the majority of persons consume malt beverages in a responsible and non-injurious manner, the brewing industry believes that those suffering from alcohol problems ought to have properly identified and professional treatment for these difficulties.

Believing that brewing industry employees deserve nothing short of the best available occupational programs, the Social Systems Science Unit of the Wharton School was commissioned by the United States Brewers Association, Inc. and Anheuser-Busch Companies, Inc., a USBA member company, to prepare a comprehensive manual on how best to establish Employee Assistance Programs (EAP's). The authors of this manual conducted an extensive literature review and held consultations with leading experts in the occupational programming field, the business community and organized labor.

By 1980, when this manual was completed, a number of brewers had already established worksite programs for their personnel. Consequently, USBA had to decide on a course of action which would maximize the comprehensive research completed by the Wharton School.

The end result was a step-by-step guide for establishing and maintaining occupational programs. Designed primarily for use by personnel administrators, the manual provides a broad framework for setting up programs in organizations of all sizes.

In April 1979, Secretary Califano of the Department of Health, Education, and Welfare (now, Department of Health and Human Services) challenged the private sector to acknowledge the humanitarian and economic value of occupational programs and to extend these EAP's to additional workers. It became evident that the USBA-funded manual, Employee Assistance Program...A Model, could constructively assist in achieving this objective.

So that the working professionals in the field had access to the manual USBA participated last fall in the Association of Labor Management Administrators and Consultants on Alcoholism, Inc. Convention held in San Diego, California. This resulted in the distribution of hundreds of copies of the Model EAP to Convention participants.

In addition to distributing these manuals to the entire brewing industry, copies were made available to the following agencies:

-State Liquor Control Administrators
-State Alcoholism/Alcohol Abuse Agencies
-State Chambers of Commerce
-Key Federal Government Agencies and Administrators
-Voluntary Organizations in the Alcoholism Constituency

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) within the Department of Health and Human Services (DHHS) had the opportunity to review this manual and former NIAAA Director, John R. DeLuca, made the following observations on its content:

> "The Model Program reflects the latest knowledge in occupational programming. Its systematic and comprehensive presentation of the elements of quality programming and

> pitfalls to avoid offers practical advice that will be useful to industry and labor in devising effective programs."
>
> "I congratulate you and the Brewers Association for the development of this Manual and its dissemination and am pleased to commend it to organizations interested in establishing and strengthening occupational programs."

Further support on USBA plans to disseminate this model program was voiced by State agencies involved in alcoholism and drug abuse agencies. For example, the Executive Director of the Governor's Council on Drug and Alcohol Abuse in Pennsylvania wrote the following to USBA President, Henry B. King:

> "Thank you for sending me a copy of the Employee Assistance Program Model developed by the Alcohol Programs Division, USBA, Inc."
>
> "I was most impressed with the content of the publication and personally congratulate all those who were involved in its development."
>
> "...Your publication will certainly serve as a model to our state and will be most useful for training purposes."

The Department of Alcohol and Drug Programs, State of California Health and Welfare Agency, requested one hundred copies of USBA's manual for administrators in their county alcohol and drug programs who required..."quality information on employee assistance programs."

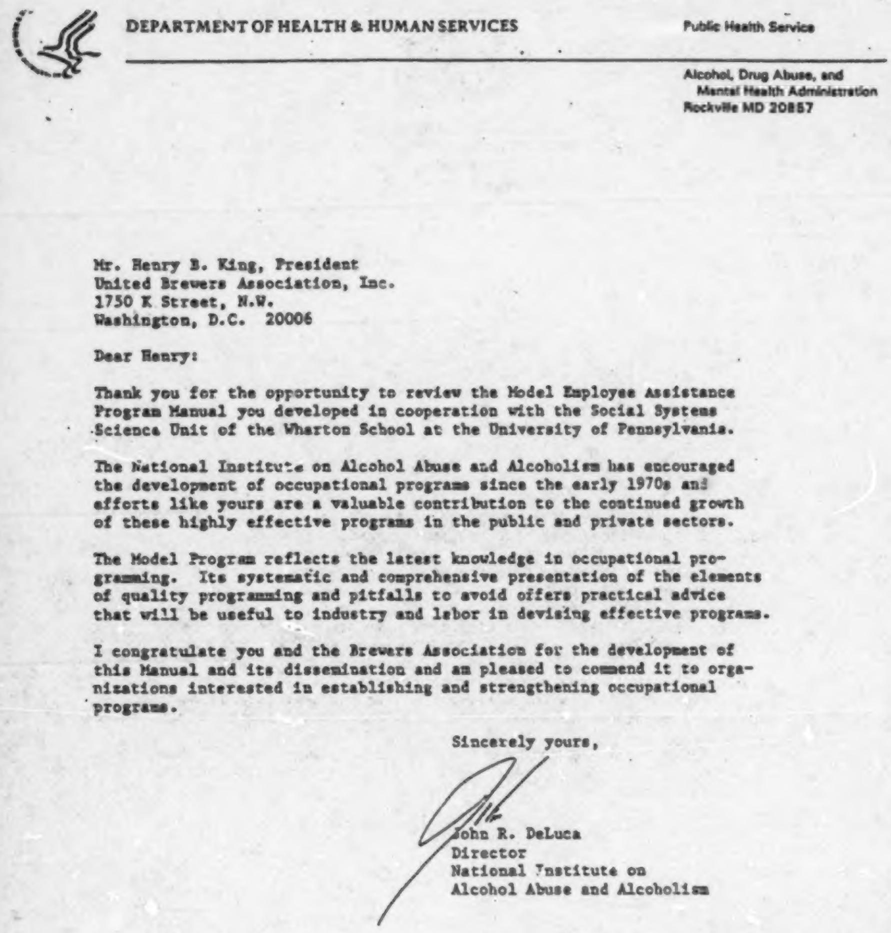
These letters are attached to this statement for your information. Additionally, voluntary sector agencies were provided with these model program outlines. Mr. Jim Zanardi, Central Kansas Foundation for Alcohol and Chemical Dependency, wrote the following upon receiving this EAP manual:

> "In making comparisons among current E.A.P. literature available,

I have found two sources excellent, your USBA Manual and "The Employee Assistance Program" by Jim Wrich, Hazelden."

Mr. Chairman, we note these commendations not to advance the EAP manual prepared under a USBA grant; rather, we strongly feel that the sentiments expressed therein demonstrate the need for the further establishment of occupational programs. You and the members of the respective Subcommittees have demonstrated the resolve of the United States Congress to demonstrate the need for positive actions by the public and private sector to assist troubled employees. If, in your efforts, you should require a model program to share with interested organizations, USBA will be pleased to offer this model program for that purpose. We are enclosing a copy of this manual to each Subcommittee and would welcome any comments on how USBA can be of assistance to your efforts.

DBS/deb



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

Mr. Henry B. King, President
United Brewers Association, Inc.
1750 K Street, N.W.
Washington, D.C. 20006

Dear Henry:

Thank you for the opportunity to review the Model Employee Assistance Program Manual you developed in cooperation with the Social Systems Science Unit of the Wharton School at the University of Pennsylvania.

The National Institute on Alcohol Abuse and Alcoholism has encouraged the development of occupational programs since the early 1970s and efforts like yours are a valuable contribution to the continued growth of these highly effective programs in the public and private sectors.

The Model Program reflects the latest knowledge in occupational programming. Its systematic and comprehensive presentation of the elements of quality programming and pitfalls to avoid offers practical advice that will be useful to industry and labor in devising effective programs.

I congratulate you and the Brewers Association for the development of this Manual and its dissemination and am pleased to commend it to organizations interested in establishing and strengthening occupational programs.

Sincerely yours,

John R. DeLuca
Director
National Institute on
Alcohol Abuse and Alcoholism

Commonwealth of Pennsylvania
GOVERNOR'S COUNCIL ON DRUG AND ALCOHOL ABUSE
2101 North Front Street
Harrisburg, Pennsylvania 17120

DICK THORNBURGH
Governor

GARY F. JENSEN
Executive Director

February 25, 1981

Mr. Henry B. King, Esquire, President
United States Brewers Association, Inc.
1750 K Street, N.W.
Washington, D.C. 20006

Dear Henry:

Thank you for sending me a copy of the Employee Assistance Program Model developed by the Alcohol Programs Division, USBA, Inc.

I was most impressed with the content of the publication and personally congratulate all those who were involved in its development.

In Pennsylvania we currently have in effect a State Employees Assistance Program for all state employees in need. Furthermore, as the Single State Agency we have the responsibility to provide consultation and technical assistance to private industry concerning the initiation of EAP's, upon request. Your publication will certainly serve as a model to our state and will be most useful for training purposes.

I again thank you and your excellent staff for a job well done.

Best wishes.

Sincerely yours,

Gary F. Jensen
Executive Director

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

Department of Alcohol and Drug Programs
111 Capitol Mall
Sacramento, California 95814

June 12, 1981

Mr. Donald B. Shea
Assistant Director
Alcohol Programs Division
United States Brewers
Association, Inc.
1750 K Street, N.W.
Washington, D.C. 20006

Dear Mr. Shea:

Thank you very much for the 104 copies of the United States Brewers Association's manual: Employee Assistance Programs...A Model. We truly appreciate your Association's cooperation in this matter.

As I indicated in my previous letters, we are sharing these manuals with our county alcohol and drug program administrators in order to disseminate quality information on employee assistance programs.

The manual is excellent. Presently I am at a loss for constructive suggestions on its improvement. Once others have read the manual and started using its principles, perhaps they may have some positive ideas to share with you. Again, thank you for your generous assistance.

Sincerely,

Ruben R Gomez

RUBEN R. GOMEZ, Assistant
Employee Assistance Programs
(916) 323-2090

cc: Tom Jones

Central Kansas Foundation
for Alcohol and Chemical Dependency
TELEPHONE (913) 825-6224 • POST OFFICE BOX 1860 • 501 NORTH FIFTH STREET • SALINA, KANSAS 67401
A United Way Agency

February 2, 1982

Mr. Jim Zanardi
E.A.P. Representative
Central Kansas Foundation
P.O. Box 1860
Salina, Kansas 67401

Mr. Chris Valauri
Director of Communications
U.S.B.A.
1750 K N.W.
Washington D.C. 20006

Mr. Valauri, ←

I appreciate your positive response to my inquiry concerning U.S.B.A.'s E.A.P. manual. I was introduced to it at an E.A.P. training seminar at Washigton University, St. Louis, MO. Mr. Jim Ray, then E.AP. Director at Anheuser-Busch Brewery at St. Louis, provided chapters 1-2 & 3 to seminar participants as an exemplary model for E.A.P.'s.

In making comparisons among current E.A.P. literature available, I have found two sources excellent, your U.S.B.A. Manual and "The Employee Assistance Program" by Jim Wrich, Hazelden.

It is extremely necessary that excellent E.A.P. resources be available to ensure continued professionalism so necessary in our field. I wish to emphasize that the U.S.B.A. E.A.P. manual fills that requirement. Congratulations on your effort!

Sincerely,
Jim Zanardi
Jim Zanardi
CENTRAL KANSAS FOUNDATION

JZ/se

cc: file

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STATEMENT OF

CHARLES MEYERS

COORDINATOR, OCCUPATIONAL PROGRAMS

ALCOHOLISM CONTROL ADMINISTRATION

STATE OF MARYLAND

FOR THE

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

AND THE

SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

U. S. SENATE

The quality and quantity of the witnesses at the hearing on July 14, 1982, were very impressive. It was obvious to all that the costs of alcoholism and drug abuse in the workplace, both to employer and employee, are indeed astronomical, and that good occupational programs can be very effective in restoring employees to healthy productivity. I found it interesting that Senator Quayle asked why occupational programs had not found universal acceptance, since they have proven to be so effective. I do not prefess to know all the answers to that question, but would like to share some conclusions reached in six years of experience as an Occupational Program Consultant (OPC) for the State of Maryland. A major stumbling block to acceptance lies in the original approach. Most employers, like most Americans, still cling to the "skid-row bum" image of the alcoholic and the "dope fiend" image of the drug abuser, which leads to a denial that any such problems exist in their workplace. An OPC presenting a program as a way to deal with alcoholic and/or drug abusing employees is met with an attitude that basically says, I'm not stupid, we don't hire, skid-row bums and/or dope fiends," or "My God, here comes another one of those do-gooders that wants me to coddle drunks and addicts, as if we don't have enough trouble around here already." Getting someone to accept any sort of change is difficult enough, without having to overcome the aforementioned obstacles. Public education is removing some of these roadblocks, but slowly.

The Maryland Center for Quality and Productivity in the Workplace has stated, "Unless we solve the problem of productivity, our children will be the first generation in the history of the United States to live worse than their parents." Part of this problem lies in the antagonism between labor and management that has been growing for quite a few years which has moved to the floor of the workplace. A major benefit of the occupational alcoholism effort has been the development of the Employee Assistance Program (EAP), which offers supervisors and shop stewards a way to work cooperatively in returning to productivity employees whose work performance has become unsatisfactory, preferable to the adversary position often taken between shop stewards and superviosrs over employee behavior. Good programs teach supervisors and shop stewards that troubled employees often need professional help and will respond positively when approached appropriately. Having participated in hundreds of supervisors training sessions, I have become award that many supervisors go through a four-stage process in dealing with problem employees. The four stages are:

1. "Praying for a miracle." Ignore employee behavior as long as possible hoping for a change.

2. "Reason will prevail." Usually generalized remarks to the entire work force about "unacceptable behavior" hoping that the problem employee "gets the Point."

3. "Pleading." Random begging, cajoling, and threatening the employee.

4. "Bleeding." Finally discipline, forced resignation, transfer, or retirement of the employee.

(4 stages courtesy of the booklet "Turning Supervisors On," by Phillips, Purvis, and Older - Hazelden Foundation.)

In the "Bleeding" stage, supervisors go through a process of harassment, spying, writing everything in the "little black book," all guaranteed to further create labor-management friction. Good EAP supervisor/shop steward training teaches that employees should be offered a chance to improve their behavior before the "Pleading" or "Bleeding" stages are reached. Supervisors learn to substitute a more positive four-step procedure:

1. The "water-cooler talk." An informal talk with the employee about his/her work performance, offering a referral for counseling if the employee is experiencing personal difficulties.

2. Written warning. If inappropriate behavior persists, give a written warning that possible disciplinary action may be used if performance decline continues. An offer of referral to counseling is again made.

3. Discipline or assistance. If performance decline has continued, employee is offered a choice between accepting discipline or a referral for counseling.

4. Discipline, If employee has refused assistance, and performance has continued to decline. Discipline must be utilized to prove that situation is serious.

These steps take the superviosr, shop steward, and employee out of the game of one-upmanship so destructive to the workplace, into the posititive non game of constructive health building. The EAP is an idea that offers much to the American workplace.

Senator **Quayle**. Thank you very much. I want to thank the panel for very aptly summarizing what the whole discussion today has been. I believe that your testimony on the individual programs and the cooperation that has been expressed between the management and the union in the individual businesses that are having successful employee assistance programs speaks for itself.

Hopefully, what we have gained today will serve as a catalyst for further exploration into this very important area. I can only tell you that your very thorough and deliberate testimony was certainly appreciated by me and will be very useful to the committee and the staff as we pursue this area.

So, on behalf of other members who were not present today, I want to thank you profoundly for very substantive, detailed, and thoughtful comments. I have certainly enjoyed it and I am to be the beneficiary of those.

With that, the committee will stand in recess.

[Whereupon, at 2:10 p.m., the subcommittee was adjourned.]